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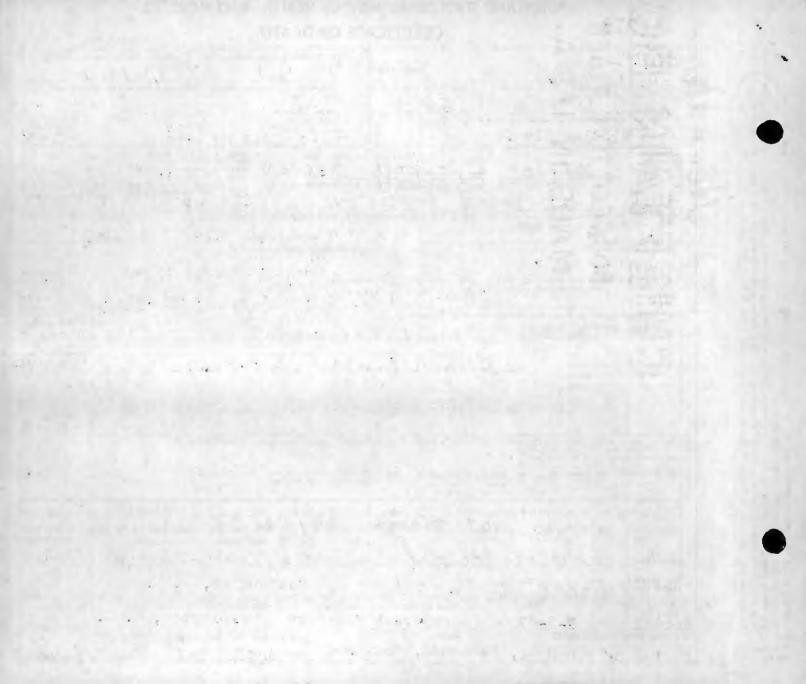
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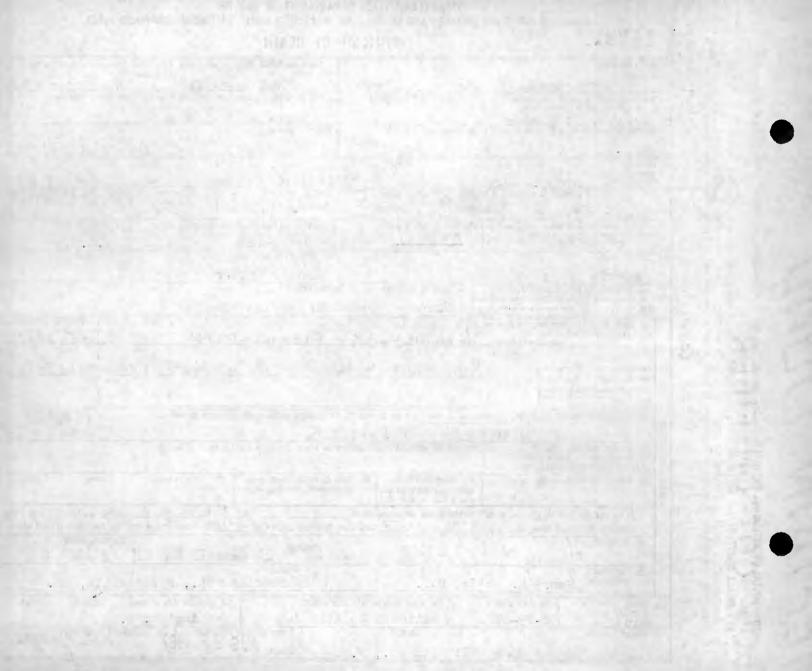
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11280 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death funeral and 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY fromery b. COUNTY papers. Pages 1 hin 72 havrs after MARYLAND montgomerces b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town) write RURAL and give morest town) TAKOMA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) filled in d. STREET ADDRESS e IS RESIDENCE ON A FARM? 9063 MANChes YES NO W campletely fi NAME OF Middle DATE Month Year First Day DECEASED OF ElOISE ENNE 196 (Type or print) DEATH IF UNDER 24 HRS. 5. SEX 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH AGE (In years IF UNDER 1 YEAR **NEVER MARRIED** please remave last birthdoy) Manths Dovs Hours WIDOWED DIVORCED burial, cremation, ar remayal, and in any and 10g. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life/even if retired) Dwn home COUNTRY? physician Je RIEL 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Theresa Abbox 17 INFORMANT Manchester Road WAS DECEASED EVER IN U.S. ARMED FORCES? 16/SOCIAL SECURITY NO permit. (Yes, no, grunknawn) (If yes give wor ar dates af service) T54-20-9440 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-transit p SNSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Canditions, if ony, which gove rise to immediate couse (o). DUE TO stoting the underlying couse Page 4 may be retained by the haspital ar attending TO FUNERAL DIRECTOR: After this certificate has been director, page 3 shauld be detached for use as the should be filed with the State Dept. af Health priar to ATTENDING PHYSICIAN: The law 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES NO 20o. ACCIDENT WAS UNDERLYING [] 20b, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) 20c. TIME OF INJURY Month, Day, Year 20f (County) (State) Hour a.m. factory, street, affice bldg., etc.) Nat While 19 of wark 21. I certify that (1) (this haspital) attended the deceased from July 23, 19 65 to club 500, 19 67 that (1) (we) last saw the deceased alive an account of the deceased alive and the date stated above. U 196 that (1) (we) last 22a. SIGNATURE 22b. DATE SIGNED ATTENDING August 8 M.D. DIRECTOR PHYS. PHYS. ADDRESS 22c. PHYSICIAN'S Scluer) NAME (Type) 23o. BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) BREMOVAL (Specify) Parklawn Cemetery Aug 10 Rockville. Maryland 250. REC'D BY REGISTRAR 967256. RECOPRARS DATE AUG VR A15 (4) Inc. 20 M 1/66 Pumphrey, Warner

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET. BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11282 within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY Tely filled in by the functions pages 1 dependence of your pages 1 dependence of your pages 1 dependence of the page of the pa MONT GOMERZ MARYLAND MONTGOMER b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) CLENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPRIN SILUFR SPRING-ILUFR e. IS RESIDENCE d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) L. ON A FARM? 06 NO F YES. 200 LOCKWOOD HOL) HOSPITAL NAME OF 4. DATE Month Year DECEASED 19 Type or print) MARCELLA ESMICK DEATH requires that the death certificate be executed IF UNDER 1 YEAR 9. AGE (In years IF LINDER 24 HRS DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost dirthdoy) Hours Sept. 29,1904 ond in any FEMALE WIDOWED DIVORCED dnd J 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. 81RTHPLACE (County & State, or foreign country) during most of working life, even if retired) COUNTRY? INDUSTRY signed by the attending physicion burial-tronsit permit. Then please New Jersev 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removo. Esther Netter Morris Jaffe WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, ar unknown) (If yes give wor ar dotes of service Nathan Resnick Unknown Same as 2 cremation, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line far (o), (b), and (c).) burial-tronsit p PART I. DEATH WAS CAUSED BY MTRICULAR FIBRILLATTOM IMMEDIATE CAUSE (a) 00 **DUE TO** HATERIOSCIEROTIC HEART DISEARE 40 YEARS Canditians, if any, which gave rise to immediate cause (a), **DUE TO** stating the underlying couse be retained by the hospital or attending last. 19. WAS AUTOPSY PERFORMED? 200 PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) for use Health IAB NO this certificate 20b. DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Part I or Port II of item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH d, (IF EITHER, NOTIFY MEDICAL EXAMINER with the State Dept. 20e, PLACE OF INJURY (Home, form, (City or town) (State) 20d. INJURY OCCURRED (County) 20c. TIME OF INJURY Month, Doy, Year Hour a.m. foctary, street, affice bldg., etc.) Not While TO FUNERAL DIRECTOR: After ot work 21. I certify that (I) (this haspital) attended the deceased from 19.53 to 22 AUG , 1962, that (I) (we) last saw the deceased alive an 22 AUG 1967, and that death occurred at 5 nPM, from causes and on the date stoted above. 22a. SIGNATURE 22b. DATE SIGNED ATTENDING DIRECTOR M.D. PHYS. ed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Henry R. Wolfe, M.D. 905 Sheridan St., Hyattsvliie, Md. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF (County) (State) 23a. BURIAL, CREMATION REMOVAL (Specify) 8-25-67 National Capital Hebrew Washington, D. C. Burial 256. REGISTRAR'S SIGNATURE 25a. REC'D BY REGISTRAR ADDRESS 24. FUNERAL DIRECTOR 4217 9th St., N.W. Goldberg Funeral Home



Maryland

25b. REGISTRAR'S SIGNATURE

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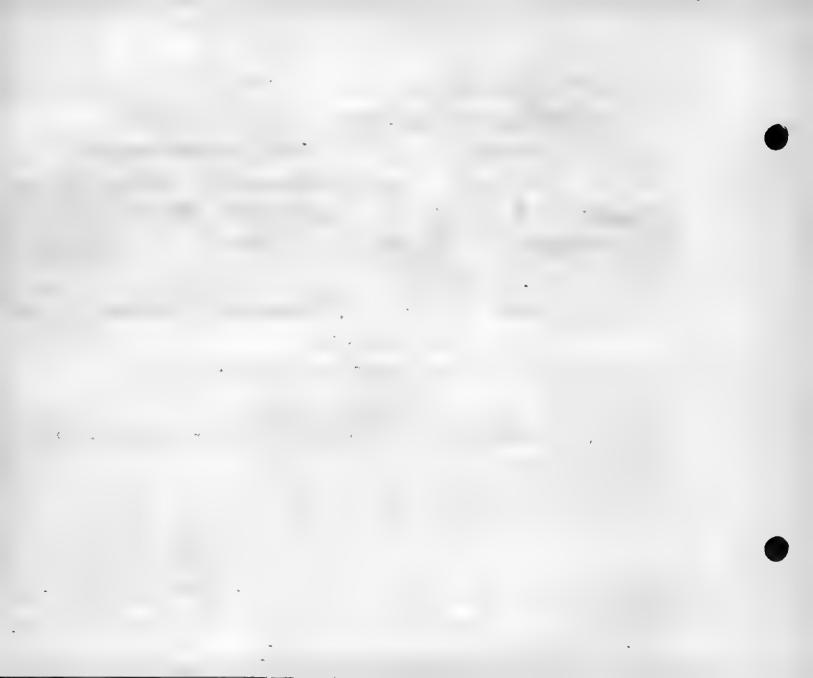
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11284 CERTIFICATE OF DEATH CVI Gled in by the funeral papers. Pages 1 and 2 thin 72 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. COUNTY b. COUNTY OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after MARYLAND of outside corporate limits, C. LENGTH OF STAY IN 16 c CITY OR TOWN (if outside carparate limits, write RURA; and give negrest town) give negrest taxen OR INSTITUTION (If not in haspital, give street address? e. IS RESIDENCE ON A FARM? 70 YES NO K 3. NAME OF Middle DATE У вот campletély DECEASED OF DEATH (Type or pont) b NEVER MARKIED IF UNDER 1 YEAR 6. COLOR OR AGE (In year) IF UNDER 24 HRS Months Dovs Hours remaval, and in any WIDOWED DIVORCED Do USUAL OCCUPATION (Give kind of work done IDE KIND OF BUSINESS OR BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending poermit. The WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANE 16. SOCIAL SECURITY NO (Yes, no, or belingwn). (If yes give wor or dates of service 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO signed I BLADDER Conditions, if any, which gave 1 rise to immediate couse (a), DUE TO stating the underlying couse peen bst. 19. WAS AUTOPS <u>50</u> PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) NO F certificate 20a ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 11 of item 1B) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 2De PLACE OF INJURY (Home, form, 20c TIME OF INJURY Month, Dov. Year 20d INJURY OCCURRED 20f (City or fawn) (County) (Stote) Hour o.m. While Not While foctory, street, office bldg., etc.) of work O FUNERAL DIRECTOR: After 21. 1 certify that (1) (this haspital) attended the deceased from TULY 17 1967 10 AUG 13 . 19 52 that (1) (we) lost sow the deceased olive on AVE 13 1967, and that death occurred at 3.1% M, from causes and on the date stated above 220. SIGNATURE-22b. DATE SIGNED ATTENDING PHYS. STAFF PHYS M.D DIRECTOR r, page 3 be filed 22d. ADDRESS 22c PHYSICIAN'S 8218-WISCONSIN NAME (Type) DONOVAN BETHESDA MO 230 BURIAL, CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (State) REMOVAL (Specify) 8-16-67 Grandlawn Cemetery Detroit Mich ELHNERAL DIRECTOR VR A15 (4) 25M 1/67 DATE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) COUNTY Stole Deportment of 7000 MARYLAND b (ITY OR DWN (f outside derporate limits, write RURA, and give nearest town) OR TOWN (If outside corporate limits, write RURAL and give nearest (Jwn) L LENGTH OF STAY IN 16 OTOTIEC NAME OF HOSPITAL OR INSTITUTION (finot in hospital give street address) d STREET ADDRESS B IS RESIDENC form ON A FARM? in Item 18 Give Pages YES be executed within 24 hours ofter death shauld be forworded to the Chief Medical Examiner's Office along with NAME OF Middle DATE Month Doy Year DECEASED OII DEATH (Type or pont) S SEX 6 COLOR OR RACE AGE (In years) 7 MARRIED NEVER MARR FD. Jost birthdoff Months within 72 hours ofter death. WIDOWED DIVORCED permit. File poges 1 and 2 10o USUAL OCCUPATION (Give kind of work done 106. KIND DE BUSENESS OR BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT dusing most of working ife, even if retired) INDUSTRY mariland 14 MOTHER SMAIDEN NAME **EATHER'S NAME** in penci margaret WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO INFORMANT (Yes, no, or unknown) Iff yes a ve wor or dates of service) 14-30-0832 IB CAUSE OF DEATH (Enter only one couse per ne for (a), (b), and (c) PART I DEATH WAS CAUSED BY: -ONSET AND DEATH in any event ExSonguetion IMMEDIATE CAUSE (c) pleose execute the certificote, writing the word " This certificate should DUE TO Shot gun- Wound -Conditions, if ony, which gove (b) nse to immediate couse (a). DUE TO stoting the underlying couse 0 and pe nsed 19 WAS AUTOPSY PERFORMED? cremotion, or removol, PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION OF GIVEN IN PART 1(0) CERT:FICATION YES X NO 20a EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of Item 18) 3 should CAUSE OF DEATH MEDICAL 20d INJURY OCCURRED 20c T ME OF INJURY Month, Doy, Year 20e PLACE OF INJURY (Home form (County) (Stote) foctory, street office bldg , etc.) While Not While FUNERAL DIRECTOR: Poge Potomac - Mont of work ot work 21 I certify that I took charge of the remains described above, held an Autapsy [X] Inspection 🔀 Inquiry X and in my apinion Naturol causes Undetermined monner death resulted from: Accident Surcide . Homicide X funeral director. be retoined CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASS STANT MEDICAL EXAMINER Health prior SIGNATURE O DEPUTY DEPUTY MED CAL EXAM NER **EXAMINER'S** may Address (Street, city, town, or county) NAME (Type) John G. Ball 230 BURIAL CREMATION 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) 400 Burial (Specify) 8/10/67 Forest Oak Gaithersburg Funeral Home-1331 Rockville Pike 124 FUNERAL DIRECTOR Ler 250 REC'D BY REGISTRAR VR A15ME (5 6M 1/67 Rockville Md.



MAKTLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 31288 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where decapted lived, if institution. Residence before admission) a COUNTY b COUNTY MARYLAND b CITY OR TOWN (If outside core write RURA) and give nearly c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS ON A FARM? 3 NAME OF Middle and camp etely t remayer carban 4 DATE DECEASED OF. (Type or print) DEATH and in any event 6 COLOR OR RACE DATE OF BIRTH AGE (In years 7. MARRIED NEVER MARRIED hurthdoy) Doys Hours WIDOWED 🔀 DIVORCED Wheek and On JSUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Country & Stole or foreign country) 12. CITIZEN OF WHAT Own Home during most of working life even is retired HOUSERACKA 13 FATHER'S NAME 34 MOTHER S MAIDEN NAME ar remayal, Thaddeus Florence Whites 16. SOCIAL SECURITY NO 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMAN (Yes, no, or unknown) lift yes give wor or dotes of service) 215-54-6009 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c))
PART I DEATH WAS CAUSED BY: ONSET AND DEATH Coronary insufficiency IMMEDIATE CAUSE (o) 4201 DUE TO Advanced Coronary arteriosclerosis Vears Conditions, if only, which gove rise to immediate cause (a). DUE TO stating the underlying couse last PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? Uremia, arteriolar and arterial mephrosclerosis & cerebral arterioscl+ vsx 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of Item 184 OR 18 20o. ACC DENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Dov. Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (Eity or town) (County) (Stote) Hour a.m. Not While factory, street, office bldg., etc.) of work ol work 21. I certify that (I) (this haspital) attended the deceased from . 19 / that (I) (we) last 10 Fin Lo Page 4 may be retained Wiley 1967, and that death accurred at 67 M, fram conses and an the date stated above saw the deceased alive au 220 SIGNATURE 22b DATE SIGNED. MED DIRECTOR M.D. 22L PHYSICIAN S 22d. ADDRESS NAME (Type) George Sharpe 10400 Conn. Avenue. Kensington. 23d. LOCAT ON (City or Town) 23c NAME OF CEMETERY OR CREMATORY 23o BURIAL, CREMATION, 23b DATE THEREOF (County) (Stote) REMOYAL (Specify) Lincoln Crenatory REC D BY REGISTRAR Es ADDRES 34 Georgia Aviso VR A15 (4) MA AUG 25M 1/67 Juneral Home Silver Spring.



	MARYLAND STATE DEPARTMENT OF HEALTH	
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o DEPUTY M. A. A. E. B. Ecessory, please executhe functor larector. Po 5 may be retained far o Funeral Director. Health ar its designote	EXAMINER'S NAME (Type) JOHN G. BALL DEPUTY MEDICAL EXAMINER A O / o / / E Address (Street, city, town, or county) Bethesda.	MA 8/29/6
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VR A15ME (5)	ROBERT A. PUMPHREY, Bethesda, Maryland AUG 31 1967 Charles Jun	0



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11288 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. COUNTY Maruland Montgomery MARYLAND b CITY OR TOWN (If outside corporate limits c LENGTH OF STAY IN 16 c CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) write RURAL and give nearest town) Silver Spring OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours IS RESIDENCE ON A FARM? papers. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS 10601 Glenhaven Drive YES NO E 3 NAME OF Middle Month Dov Year DECEASED OF 196 (Type or print) ance's DEATH 5 SEX B DATE OF BIRTH AGE (In years IF JNDER 1 YEAR IF UNDER 24 HR 6 COLOR OR RACE 7 MARRIED NEVER MARRIED last, birthday) Hours WIDOWED DIVORCED gun 10a USUAL OCCUPATION (Give kind of work dane 10b KIND OF BUSINESS OR 12 CITIZEN OF WHA? 11 BIRTHPLACE (County & State, or fareign country) during most of working life, even if retired) Grocer **COUNTRY?** 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME -employed Henry Robey Elizabeth Martin IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMAN Address Silver Spr 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give war or dates at service) 9nn M. Joben 10601 Ylenhaven Drive INTERVAL BETWEEN ONSET, AND DEATH IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) burial-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Canditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying couse has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO YES 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part II of item 18" 2Da ACC DENT WAS UNDERLY NG ... OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 2De PLACE OF INJURY (Home, form, (City or town) (State) 2Dc. TIME OF INJURY Month, Day, Year 2Dd INJURY OCCURRED (County) factory, street, office bldg., etc.) Nat While 21. I certify that (I) (this hospital) attended the deceased fram_ IO HOSPITAL OR ATTEND Page 4 may be retained saw the deceased alive an 16 auch 1967 and that death occurred at 152M, from causes and on the date stoted above TO FUNERAL DIRECTOR: 220 SIGN BURE 22b DATE SIGNED STAFF PHYS. director, page 3 should be filed v DIRECTOR PHYS 22d ADDRESS PHYSICIAN S Thomas 90gaz NAME (Type) 23c NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) 23a BURIAL, CREMATION, REMOVAL (Spegfy) Cedar Hill Cemetery Suitland homas ADDRISH 34 Ga. Ave. 250 REC'D BY REGISTRAR VR A15 (4) Pumphrey Guneral Home Silver Spring



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 289 11288 CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission a. COUNTY d completely filled in by the fune move carban papers. Pages 1 on ny event, within 72 haurs after de a. STATE **B. COUNTY** Montgomer MARYLAND Mondetamery Maryland PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after b. CITY OR TOWN (If autside carparate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) write RURAL and give nearest town) Takoma d. NAME OF MOSPITAL OR INSTITUTION (If nation haspital, give street address) d. STREET ADDRESS e IS RESIDENC ON A FARM? 106 - A YES 🗔 NO DE 3. NAME OF 4 DATE Manth Dov Year DECEASED ÖF (Type or print) Robinson DEATH 9. AGE (In years IF UNDER I YEAR THE UNDER 24 HRS. 6. COLOR OR RACE 7 MARRIED 8. DATE OF BIRTH **NEVER MARRIED** remove, last birthday) yrs Months signed by the attending physician and ca burial-transit permit. Then please remay burial, cremation, ar removal, and in any o WIDOWED DIVORCED 2-15-03 10a. JSUAL OCCUPAT ON (Give kind of work done 12 CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 13. BIRTHPLACE (County & State, or fareign country) during most of working life even if retired) INDUSTRY COUNTRY? House wite 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending phy permit. Then Margaret J. Mone 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMAN 16. SOCIAL SECURITY NO Address (Yes, no, or unknown) (If yes give wor or dotes of service) Records - Washington Sanitarium 578-20-7500 18 CAUSE OF DEATH (Enter on y one cause per line far (a), (b), and (c).) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (o) ONSET-AND DEATH UNGESTIVE Page 4 may be retained by the haspital ar attending physician. 4751 DUE TO ASSOCIA TED Conditions, if any, which gove ? rise ta immediate cause (a). DUE TO stating the underlying cause as the PART II OTHER SIGN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED PERFORMED? be detached far use State Dept. of Health MELLITUS NO 200 ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e PLACE OF INJURY (Home, form, (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (City or fown) (County) TO FUNERAL DIRECTOR: After this Haur a.m. factory, street, office bldg., etc.) Not While ATTENDING at wark at work 21. I certify that (1) (this haspital) attended the deceased from director, page 3 shauld shauld be filed with the and that death acturred at M. from couses and on the date stated above. saw the deceased alive an-22a. SIGNATURE 22b. DATE SIGNED M.D DIRECTOR PHYS 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) 23a BURIAL, CREMATION 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) Cedar Hill Cemetery Suitland 256 REGISTRAR'S SIGNATURE ADDRESS 250 REC'D BY REGISTRAR Thursers Some VR A15 (4) 25M 1/67 1967 Milanes Judge



* 1	1	Division of STATISTICAL RESEA	MARYLAND STATE DEI ARCH AND RECORDS, 301			MORE, MARYL	ND 21201	
. 7		11289	CERTIFICATE	OF DEATH			11	230
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death be retained by the haspital or attending physician and campletely filled in by the funeral standard be detached for use as the burial-transit permit. Then please remave torban papers. Pages 12 and 3 should be detached for use as the burial, cremation, or removal, and in any event, within 72 hours after death.		PLACE OF DEATH O. COUNTY Montgomery	MARYLAND	2. USUAL RESIDENCE (W		ed lived, if institution b. COUNT	n. Residence b	efore odmission)
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VG PHY r the he er this e detack	MEDICAL	1300 p.m. 5 1.9 19 67 While	Not While Viet	E OF INJURY (Home, form, ary, street, office bldg., etc.) USIM		(City or town)	(County	
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OR AT be reta DIRECTO in 3 shu		By Moral B Moral	(0.0.0) MD	ATTENDING PHYS. 22d. ADDRESS	MED. DIRECTOR	STAFF PHYS.	22b. DATE:	ust 1967
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TO HOSPITAL Page 4 may TO FUNIRAL director, pag shauld be fil	23 I	BURIAL CREMATION, 23b DATE THEREOF	23c. NAME OF CEMETERY OR C Baltimore Nat:	ional	5501		ck Ave.	unty) (Stote) Baltimore
VR A15 (4) 20 M 1/86	2	Dippel Fineral Home Inc.	ADDRALT.imore	DATE A	UG 1	6 1967	ISTRAR'S SIGN	ATURE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11291 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after death 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) funer a COUNTY o. STATE b. COUNTRY b CITY OR TOWN c LENGTH OF STAY IN 1h E CITY OR TOWN (If guitside carparate write, write RURAICand give negrest town) (If outside corporate limit write RURAL and give nearest town) d .⊑ d STREET ADDRESS e IS RES DENCE d NAME OF HOSPITAL OR INSTITUTION (If pol in haspital give street address) ON A FARM? filled NO K YES 3. NAME OF completely nove cárban Middle Day Year DECEASED OF DEATH (Type or print) 1960 S. SEX AGE (In years F LINDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH lost birthday) Haurs Days WIDOWED DIVORCED and 10g. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY,2 13. FATHER'S NAM 14 MOTHER'S MAIDEN NAME or removal Maximillian Israel Rose ---15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service signed by the a burial-transit pe INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Orteroschitic Neshrotelerosus 7 care Conditions, if ony, which gove to rise to immediate cause (a). DUE TO for use as the l Health prior to b stating the underlying couse has been 19 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART I(g) NO OR ATTENDING PHYSICIAN: 20a ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (home, form (City or town) (County) (State) Haur a.m. Not While factory, street, office bldg., etc.) While at work L at wark **DIRECTOR:** After 21. I certify that (I) (this hospital) attended the deceased from Company to ang . 17, 1967, that (1) fwe) last 1966 1967, and that death accurred at 4:457 M, from causes and an the date stated above. saw the deceased alive an and 22a, SIGNATURE 22b DATE SIGNED ATTENDING Cure 17/96 , page be filed 22d ADDRESS O HOSPITAL TO FUNERAL NAME (Type) DRING director, should b 23b. DATE THEREOF 230 BURIAL CREMATION. 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Buria 8/18/67 Douga Cemeterv W. Roxbury, Mass. 24 FUNERAL DIRECTOR **ADDRESS**

3501-1

VR A15 (4) 25M 1/67



	1		MARYLAND STATE DEPARTMENT OF HEALTH "DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
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2		CERTIFICATION	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
00	HYSI le h his htacl Den		20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State)
6		MEDICAL	Hour a.m. While Not While factory, street, office bidg., etc.)
(0)	ATTENDING returned By CTOR: After Should be vit the Sta	-	21. I certify that (I) (this hospital) attended the deceased from May . 7 , 1966, to any 22-1967, that (I) (we) last
	E SE SE E		saw the deceased alive on 2 19 67, and that death occurred at 134M, from the causes and on the date stated above.
	OR A		ATTENDING MED. STAFF
	TAL OR may be AL DIR		22c. PHYSICIAN'S 22d. ADDRESS 2
	TO HOSPITAL OR ATTENDII Page 4 may be returned TO FUNERAL DIRECTOR: A director, page 3 should Seould be file with the S		NAME (Type) A. BLITTLE M.D 6911 5th - IN Work DC
	Pag Pag O Fi	23:	REMOVAL (Soecify)
	1- p-	20	BURIAL 8-25-6/ MT OLIVET WASH. D. REGISTRAR'S SIGNATURE
	VR A15 (4)	1	TANLON FUNERAL HOME-VIASH. D.C DATESFP 1 1967 Ochanley Judge
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1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
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The State of the S	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
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he of the sit partition	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY:
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ITAL may RAL r, p2 be fi	22c. PHYSICIANS NAME (ALE) FOR HILLIAGE M.D. 220 ADDRESS 22 WESTERN AVE
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10 To 10 Page	23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) APLINGTON Nat'l Com. Arlington, Virginia
	burial 9/5/67 Arlington Nat'l Com. Arlington, Virginia 24. FUNERAL DIRECTOR // ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
VR A15 (4) 15M 4-64	The SH. Himes Co. 2901 14th ST. N.W. DATEFP 5 1967 Ochanter Just



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH hours after death ond 2. USUAL RESIDENCE (Where deceosed lived, if institution Residence before admission) 1. PLACE OF DEATH o. COUNTY o. STATE Pages E CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 write RURAL and give nearest town requires that the death certificate be executed within 24 hours the ottending physician and complétely filled in by isit permit. Then please remave éarbare papers. Prontion, or removal, and in any event, within 72 hour e. IS RESIDENCE ON A FARM? d STREET, APDRES INSTITUTION (If not in hospital, give street address) YES | NO NAME OF DATE Middle DECEASED OF DEATH (Type or print) 9. AGE (In years & IF UNDER 1 YEAR IF UNDER 24 HRS SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED burthdoy) Months Days Hours WIDOWED DIVORCED KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10o USUAL OCCUPAT ON (Give kind of work done during most of working life, even if retired) DUSTRY **COUNTRY** 3 13. FATHER'S NAME INFORMANT Address 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dotes of service cremation, 1B. CAUSE OF DEATH (Enter only one couse per signed by the burial-tronsit p PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o) DUE TO burial, Conditions, if ony, which gove rise to immediate couse (o), **DUE TO** stating the underlying couse os the prior to be retained by the hospitol or ottending TO FUNERAL DIRECTOR: After this certificate has been lost. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) CERTIFICATION be detached for use State Dept. of Heolth YES F NO 200 ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f. (City or town) (County) 20c. TIME OF INJURY Month, Doy, Year foctory, street office bldg. etc.) Hour o.m. Not While of work of work Led 21. 1 certify that (1) (this haspital) attended the deceased fram director, page 3 should should be filed with the M, from couses and an the date stated above. , and that death accurred at saw the deceased alive an 22b DATE SIGNER 22o. SIGNATURE **ATTENDING** STAFF M.D. PHYS DIRECTOR PHYS. TO HOSPITAL O 22d ADDRESS 22r. PHYSICIANA NAME (TYDE) 0366 art 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town (County) (Stote) BURIAL CREMATION, 236 DATE THEREOF REMOVAL (Specify REGISTRAR FUNERAL DIRECTOR VR A15 (4) 20 M 1/66



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11295 CERTIFICATE OF DEATH law requires that the death certificate be executed within 24 hours after death physician and campletely filled in by the funeral en please reneave technal papers. Pages—Land PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY Montgomery b. COUNTY Maryland MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4 Days Hvattsville Bethesda d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? 3923 Livingston Rd. NO X Naval Hospital YES | in any event, within NAME OF Middle First Lost 4. DATE Year Doy DECEASED 19 67 SANCHEZ (Type or prent) Robert DEATH YEAR IF UNDER 24 HRS B. DATE OF BIRTH 9. AGE (In years S SEX 6. COLOR OR RACE 7 MARRIED **NEVER MARRIED** lost pirthdoy) Months Hours 1-8-95 Mail Other Male WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) COUNTRY? INDUSTRY USA U.S.N. Phillipine Islands Military 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remaval, the attending phys Unknown Unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service)
Yes Laura V. SANCHEZ. Hyattsville, Maryland 577-12-7929 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY. INTERVAL BETWEEN **burial-transit** ONSET AND DEATH IMMEDIATE (AUSE (6) Myocardial Infarction signed by 11201 **D**UE TO Conditions, if ony, which gove rise to immediate cause (a). DUE TO stoting the underlying couse TO FUNERAL DIRECTOR: After this certificate has been the the lost. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES 🔲 NO 🔀 Ę 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [Page 4 may be retained by the haspital OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (Stote) 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, 20f. (County) 20c. TIME OF INJURY Month, Dov. Year foctory, street, office bldg., etc.) Not While ot work of work 21 | certify that (1) (this haspital) attended the deceased from 10 August, 1967, to 14 August, 1967, that (1) (we) last saw the deceased alive an 14 August 1967, and that death accurred on 1 AM, from causes and on the date stated above. 22o. SIGNATURE 22b. DATE SIGNED AFTENDING MED. DIRECTOR M.D. director, page should be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Naval HOspital, Bethesda, Md. P.T. Kirchner M.D. 23b. DATE THEREOF 23d LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY (Stote) 23o, BURIAL CREMATION, (County) Arlington, Virginia REMOVAL (Specify) Arlington National 8/18/67 24 FUNERAL DIRECTOR ADDRESS
Lee's Funeral Home
4th & Mass. Ave., Washington, R.C. 256 REGISTRAR'S SIGNATURE 2So REC'D BY REGISTRAR Charles VR A15 (4) 20 M 1/66 1967 AUG DATE

MARYLAND STATE DEPARTMENT OF HEALTH



VR A15 (4) 20M 1/65 **FUNERAL DIRECTOR**

SIGNATURE REC'O BY REGISTRAR 25b. 20012

ON IGO MEEY

Days

12. CITIZEN OF WHAT

19.

(County)

22b. DATE SIGNEO

YES

Months

e. IS RESIDENCE ON A FARM?

Year

19

INTERVAL BETWEEN

ONSET AND DEATH

WAS AUTOPSY

PERFORMEO?

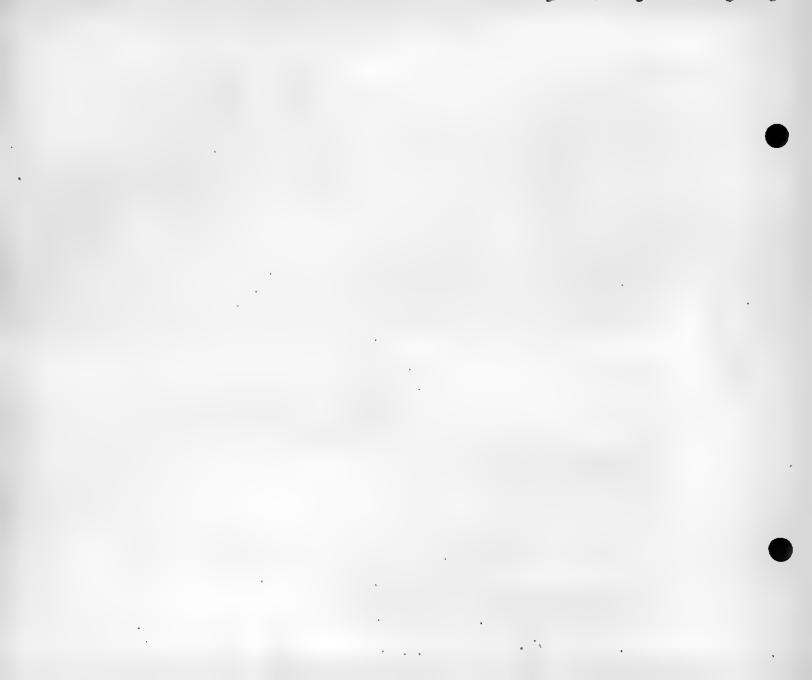
NO [

(State)

(State)

YES

NO X



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11296 11297 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e COUNTY o STATE **b** COUNTY b (ITY OR TOWN (If outside corporate limits, weite RURA, and give nearest town) MARYLAND MARYLAND MONTGOMERY c. CITY OR TOWN of outside corporate limits, write RURAL and give nearest town c. LENGTH OF STAY IN 16 CHEVY CHASE 13cTHES DA d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? .= elymented DUBURBAN MADLE NO 🔀 YES NAME OF Middle First 4. DATE Manth Lost Dov Year DECEASED (Type or pnnt) DEATH 19 67 5 SEX AGE (In years lost pirthday) IF JNDER 24 HR IF UNDER I YEAR 6. COLOR OR RACE 7. MARRIED DET NEVER MARRIED DATE OF BIRTH Manths Doys Hours in any MALE WIDOWED DIVORCED WHITE 10o USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 1). BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT physician (ien please during most of working life, even if retired) -INDUSTRY COUNTRY? Washington, D.C Ketired -13 FATHER'S NAME 14. MOTHER'S MAJOEN NAME removal. Ernestine A. Guensen attending paramit. The WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Wash D.C (Yes, na, or unknown) If If yes give war at dates of service) Ы 18 CAUSE OF DEATH (Enter only one couse per line for (o), INTERVAL BETWEET signed by the burial-transit p PART I. DEATH WAS CAUSED BY: ONSET AND DEA IMMEDIATE CAUSE (a) Canditions, if any, which gave rise to immed ote cause (o), DUE TO stoting the underlying couse the this certificate has been 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART ITO). NO P YES -OR ATTENDING PHYSICIAN: far 200 ACCIDENT WAS UNDERLYING 20b, DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 1) of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (C'v or town) (County) **NED** factory, street, affice bldg., etc.) Not While **DIRECTOR:** After be retained by 21. I certify that (1) (this hospital) attended the deceased fram. 1967, that (I) (we) las ta and that death accurred at 113 saw the deceased alive an A.M. fram causes and an the date stated above 22o. SIGNATURE 22b DATE SIGNED STAFF **ATTENDING** M.D. DIRECTOR 22c PHYSICIAN S 22d ADDRESS TO HOSPITAL IO FUNERAL NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION. 23b. DATE THEREOF LOCATION (City of Town) (County) REMOVAL (Specify) 8-15-1967 24. FUNERAL DIRECTOR Sons, VR A15 (4) Joseph Gawler's Misc 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 1.298 CERTIFICATE OF DEATH death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY Montgomery o. STATE **b.** COUNTY Sapers. Pages 1 of 10 72 hours after d MARYLAND Md. Montg. 24 hours after b. CITY OR TOWN (If outside corporate timits. c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Rockville Potoman = d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE ON A FARM? d Sintal + La P 是 YES NO TX 9721 Corral 10500 Rockville Pike Drive PHYSICIAN: The law requires that the death certificate be executed within NAME OF Cachon Į. First MATE Month Day Year DECEASED event, 19 (Type or print) SCHILLING DEATH EDTTH CRAHAM ā S. SEX IF UNDER 1 YEAR TE LINDER 74 HRS 6 COLOR OR RACE 7. MARRIED 9. AGE (In years B DATE OF BIRTH NEVER MARRIED remove lost birthday) Months Days Hours Temale White ond in ony WIDOWED DIVORCED 18. 1893 and 10e JSUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) At Home COUPLERS physician (nen please Downes Grove. Ill. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removol. Mary Shaw Edmund H. Graham ottending poermit. The 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO Address permit. (Yes, no, or unknown) (If yes give war or dates of service Walter Schilling. Same as #1 No crematian, CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)-INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) þ DUE TO signed t buriol, Conditions, if only, which gove (b) rise to immediate cause (a). DUE TO stoting the underlying couse Page 4 moy be retained by the hospital or ottending O FUNERAL DIRECTOR: After this certificate has been os the prior to b lost (c) 19 WAS ALTOPSY PERFORMED? PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) NO for use Health YES NO XX 200 ACCIDENT WAS UNDERLYING ... 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 11 of Item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or fown) (County) (Stote) MEDI Hour o.m. foctory, street, office bldg., etc) Not While of work 1966, to 21. I certify that (I) (this hospital) 1967 that (1) (we) last attended the deceased from. with the and that death accurred at 4777 M, from causes and on the date stated above saw the deceased alive an 22o. SIGNATURE 22b. DATE SIGNED **ATTENDING** director, page 3 should be filed v PHYS DIRECTOR PHYS 22d. ADDRESS 22c. **PHYSICIAN S** NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. YOCATION (City or Town) 23a BURIAL CREMATION. 23b. DATE THEREOF (County) (State) REMOVAL (Specify) Rock Creek Cemetery Burial Washington 2 250. RECTURE REGISTRAR 196756 24. FUNERAL DIRECTOR 5130 Wiscon Washington, Wisconsin Ave, NW VR A15 (4) Joseph Gawler's Sons. 25M 1/67 DATE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11298 CERTIFICATE OF DEATH 31209 OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death 2 USUAL RESIDENCE (Where deceased leved, if institution Residence before admission) PLACE OF DEATH o. COUNTY Montgomery o. STATE h. COUNTY Haryland MARYLAND Lontgomery b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 1h c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 30 days Hyattstown Olnev d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADORESS IS RESIDENCE ON A FARM? Montgomery General Hospital NO R NAME OF Middle First 4 DATE Lost Month Year DECEASED Schraver Arthur Henry 67 August 19 (Type or print) DEATH S SEX 6. COLOR OR RACE 8 DATE OF BIRTH 9 AGF (In years IF UNDER 1 YEAR JE UNDER 24 HRS 7 MARRIED 35 NEVER MARRIED lost birthdoy) Months White Male WIDOWED DIVORCEO 12-2-97 10o JSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT COUNTRY during most of working life, even if retired)
Painter Nousiry Penna. S. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Jacob Schrayer Emma Heckman IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANI 16. SOCIAL SECURITY NO Address (Yes, no, or unknown) (If yes give wor or dates of service) Medical Records 203-01-9067 1B. CAUSE OF DEATH (Enter only one couse per line for (a) (b) and (c).)
PART I. OEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) EUMONIA Conditions, if ony, which gove) rise to immediate cause (a), DUE-TO stoting the underlying couse Page 4 may be retained by the haspital ar attending CLERUSIS IO FUNERAL DIRECTOR: After this certificate has been as the PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 16s WAS AUTOPSY detached far use te Dept. of Health 20o ACC DENT WAS UNDER, YING 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port II of Item 18 OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Not While foctory, struct, office bldg., etc.) at work I certify that/(1) this hospital) attended the deceased fram , and that death occurred at A M, fram/couses and on the date stated above. saw the deceased alive on 220 SIGNATURI MEO. DIRECTOR M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) directar, shauld b 230 NAME OF CEMETERY OR GREMATORY 230 BUR AL, CREMAT ON, 23b. OATE THEREOF 23d LOCATION (City or Town) (County) REMOVAL (Specify)
Burial Cem. Etchison, Maryland Cemetery. 8-22-67 2Sb REGISTRAR S SIGNATURE REC'D BY REGISTRAR 24 FUNERAL DIRECTOR Maryland VR A15 (4) 25M 1/67 A. PUMPHREY, Bethesda,

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11360 OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) COUNTY b. COUNTY MARYLAND 100166177620 7617KONKRL CITY OR TOWN (If outside corporate limits, write, RURAL and give nearest town) cmove carban papers. Pages any event, within 72 haurs aft C LENGTH OF STRY IN 16 c CITY OR JOWN (If outside corporate limits, write RURAL and give negrest town) ⊑ d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d STREET APPRESS IS RESIDENCE ON A FARM? filled 4)01111011 YES NAME OF Middle DATE Last Manth Dov Year DECEASED leanor (Type or print) 196/ DEATH F UNDER 1 YEAR IF UNDER 24 HRS 7 MARRIED **NEVER MARRIED** 9. AGE (In years last birthday) Hours WIDOWED DIVORCED and 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CIT ZEN DE WHAT during most of working life, even if retired) "ATETERIA MAMSER 13. FATHER'S NAME 14. MOTHER'S WAIDEN or remayal. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMA Littleton S (Yes, na, or unknown) (If yes give wor or dates of service) 78-16-2084 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY INTERVAL BUTWEEN ONSET AND DEATH signed by the burial-transit p IMMEDIATE CAUSE (o) **DUE TO** Conditions, if any, which gave ase to immediate cause (a), DUE TO stoting the underlying cause has been the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH 8.1T NOT RELATED TO THE REMINAL DISEASE CONDITIONS IVEN IN PART 1(6) KATION PERFORMED? uld be detached far use the State Dept. of Health 2 NO [YES this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20g ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) factory, street, affice bldg., etc.) Nat While FUNERAL DIRECTOR: After at work 21. I certify that (1) (this hasyital) attended the deceased fram and that death accurred a 150 115M, from causes and an the date stated above. saw the deceased alive on 22m. SIGNATURE DATE SIGNED DIRECTOR M.D 22d. ADDRESS NAME (Type) director, should b 23o. BURIAL, CREMATION, 23b DATE THEREOF 1067 23c NAME OF CEMETERY OR CREMATORY 23d 10CATION (City or Town) (County) REMOVAL (Specify) Cedar Hill Cemetery Suitland. 9 Maryland 250 REC'D BY REGISTRAR Guneral Home Silver Spring.



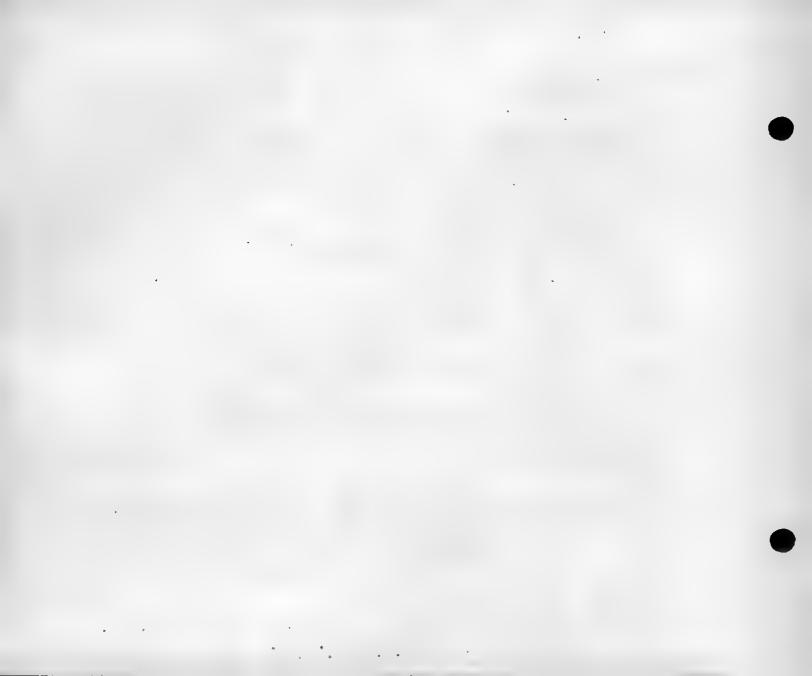


. 1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
and the same	CERTIFICATE OF DEATH	11302								
funeral funeral	1 PLACE OF DEATH O. COUNTY MOST SOME 21. MARYLAND NEW SERS	decensed lived of institution. Residence before admission)								
aurs afte by the f Pages ours afte	write RURAL and give nearest tawn)	carparate minus, write KUKAL and give nearest town)								
Muthin 24 haurs aftraphies of the self filled in by the self gappers. Pages within 72 hours aft	d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) Of the street address of the str	Hampton IT and o IS RESIDENCE ON A FARM? YES NO IN								
d within derby fill within	3 NAME OF First Middle Last 4, 5	DATE Month Doy Year OF JEATH AUC 16 1967								
executed and compli- remove of	5. SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED B DATE OF BIRTH TEMPLE CRUC WIDDWED DIVORCED 11-8-84	9. AGE (In years IF JNDER 1 YEAR IF UNDER 24 HRS Jast birthday) Months Days Hours Min								
e deoth certificate be ex ottemating physician and permit. Tillen please rem an, or removal, and in an	100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIREO 10b. KIND OF BUSINESS OR INDUSTRY COUNTY GOVT- NEW YORK	e or foreign country) 12 CHT ZEN OF WHAT COUNTRY?								
certificc g physi moval,	13. FATHER'S NAME WILLIAM STILWELL 14. MOTHER'S MAIDEN NAME LILLIAN	DAVIS								
he deoth i offe≣din permit. Ì ion, or re	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or upknown) (If yes give wor or dates of service) 138-30-6153 NOSP. RECORD									
of th	18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) CARCINOMA DUE TO DUE TO	ONSET AND DEATH								
OR ATENDING PHYSICIAN: The low requires the be retoined by the hospital or attending physician. JUNECTOR: After this certificate hos leen signed by pe 3 shauld be detached for use as the burial-troiled with the State Dept. of Health prior to burial, cre	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	3 Mo.								
The low attendi attendi hos lie se as the prior	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION	PERFORMED?								
TO HOSPITAL OR ATTENDING PHYSICIAN: The low re Page 4 may be retained by the hospital or attending TO FUNETAL INRECTOR: After this certificate has Leen director, page 3 shauld be detached for use as the should be filed with the State Dept. of Health prior to	200 ACCIDENT WAS UNDERLYING 200 DESCRIBE HDW INJURY OCCURRED (Enter nature of injury in Port OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
NG PHY / the ho er this c detach ate Depi	20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 20d INJURY OCCURRED While of work of wor	20f (City or town) (County) (State)								
TTENDIR Dined by OR: Aftr Could be		to 76, 1967, that (I) (we) las SeM, fram causes and an the date stated above								
D HOSPITAL OR ATTENE Page 4 may be retained D FUNETAL DIRECTOR: A director, page 3 should should be filed with the	220. SIGNATURE Les W. Cecitis M.D. ATTENDING MED DIRECT PHYSICIAN'S 22d. ADDRESS 22d. ADDRESS	tor D-46-559 22b DATE S GNED								
TO HOSPITAL of Page 4 may be file director, page should be file	NAME (Type) LEO. M. CURTIS. 8218 WISC									
Page Page direc	Removal 8-16-1967	Metalchen Registrar's Signature								
VR A15 (4) 25M 1/67	24 FUNERAL DIRECTOR AWI er's Sons, Inc ADDRESS 250. REC'D BY R 5130 Wisc. Ave. N.W. Wash.D.C. DAMAUG Z	1 1967 Killarles Juages								



my -		Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201							
FOR STATE		11302 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 22303							
HEALTH DEPT.		PLACE OF DEATH O COUNTY O STATE O STATE O COUNTY D							
200	portment of after deoth.	b CITY OR TOWN (If outs de corpaged limits, write RURAL and give nearest tawn) write RURAL and give/nearest (awn)							
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ofter death 8. Give Page along with 1	72	3 NAME OF DECEASED (Type or print) March Regard Cate Shanks DEATH 8-6 1967							
	1	S. SEX 6. COLOR OF RACE MARRIED 8 DATE OF BIRTH 9 AGE (In years IF UNDER 14 HRS Min Months Days Hours Min Months Days Hours Min							
within 24 hours pencul in Item 11 xaminer's Office	lond2 event	10b. USUAL OCCUPATION (Give kind of work done done libb. KIND OF BUS NESS OR DESCRIPTION (Give kind of work done libb.)							
hin 24 ncd in niner's	poges lo in any e	13. FATHOR'S NAME 1 14. MOTHER'S MAIDEN NAME 8/1							
ad wit in pe I Exan	File	15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address (Yes, na, ar unknawn) (If yes give war ar dates of service)							
ecute ling" edico	ermi	Husbana - Occir G. Same							
be ex "pend hief M	(Yes, na, arunknawn) (If yes give war ar dates af service) 18 CAUSE OF DEATH (Enter an y ane cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY Myocardial Infarction, Posterior IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gove rise to immediate cause (a). (b) Coronary arteriosclerosis								
word word	rial-tr tion,	Conditions, if ony, which gove) (b) Coronary arteriosclerosis							
This cert ficote should be executed icate, writing the word "pending" in be forwarded to the Chief Medicol E	0 2	rise ta immediate cause (o). stoting the underlying cause							
cert fic writin rward	used os burrof, c	PART I OTHER SIGNIFICANT CONDITIONS CONTRIBITING TO DEATH RUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CHICAN IN PART ICA).							
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INER: 1 e certific should b	3 should bent, prior	200 EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH 200 DESCRIBE HOW INJURY OCCURRED (Enter nature of in try in Port I or Port I of tem 18)							
ME. AL EXAMINER: pleose execute the cert director. Page 4 should retained for your files.	age 3 s	20c TIME OF INJURY Manth, Doy, Year Hour a.m. 19 While at work							
L EXA recute Page	ated	21. I certify that I taak charge of the remains described above, held an Autapsy 🔀, Inspection 🔀, Inquiry 💢, and in my apin'a							
ME.: A soleose explesses experient	ECTO Sign	death resulted fram: Natural causes X, Accident , Suicide , Hamicide , Undetermined manner							
pleo:	L DIR	ACTUAL SIGNATURE OAM G. Ball CHIEF MEDICAL EXAMINER (22. DATE SIGNED							
FO DEPUTY necessory, p the funeral	O FUNERAL DIRECTOR: Page Health or its designated age	DEPUTY MEDICAL EXAMINER Q 8/6/67 - NAME (Type) Address (Street, city, town, or county)							
nece the	TO FU	236 BURIAL CREMATION, PREMOVAL (Specify) Burial 8-9-1967 Parklawn Cemetery Rockville Md							
VR A	15ME (5)	Burial 8-9-1967 Parklawn Cemetery Rockville Md 24 FUNERA. DIRECTOR Joseph Gawler's Sons, Inc. N. W. Sh. DC. Volate AUG 3 1967 Clearley Judge							

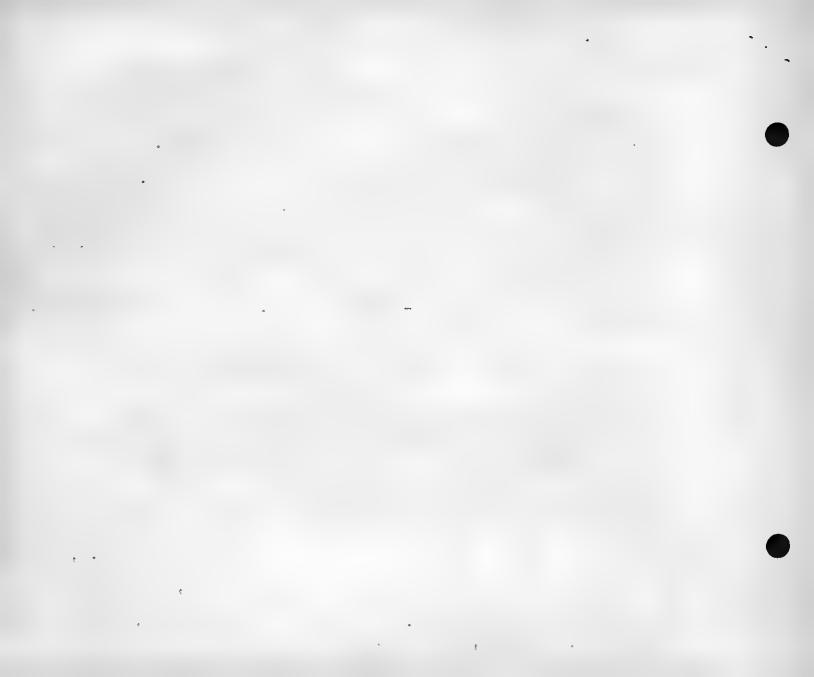
MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11304 CERTIFICATE OF DEATH 11303 PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death ond deogle PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) Montgomery o. STATE Maryland b. COUNTY ely filled in by the function popers. Pages 1 c MARYLAND Montgomery b CITY OR TOWN (If outside corporate limits, c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest fown) C LENGTH OF STAY IN 16 Silver Spring Olney d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS IS RES DENCE ON A FARM? 12325 New Hampshire Ave. 3501 Emory Church Road YES NO THE 3 NAME OF 4. DATE Month Inst Year etely DECEASED OF DEATH GRACE SHERTZER August 20,1967 (Type or print) 6 COLOR OR RACE TELINDER I YEAR IF UNDER 24 HRS 7. MARRIED 8. DATE OF BIRTH 9 AGE (In years NEVER MARRIED 70 lost birthday) Hours White Aug. 23.1887 ottending physician ond co sermit. Then please remai Female WIDOWED DIVORCED cremotion, or removal, ond in any 10a USUAL OCCUPAT ON (Give kind of work dane 10b KIND OF BUSINESS OR 12 CTIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) who most of working life, even if retired) INDUSTRY COUNTRY Virginia Housewife USA Own Home 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME John Thomas Payne Mary Virginia Claggett 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, ar unknown) (If yes give war or dates of service 579-03-0165-D Beverly G. Morgan-Item # 2 No 18 CAUSE OF DEATH (Enter only one cause per one for (a), (b) d (c).) INTERVAL BETWEEN signed by the buriol-transit p PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OUE TO Conditions, 'f any, which gove rise ta immediate cause (a), DUF TO stating the underlying couse last PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) hos 19 WAS AUTOPS PERFORMED? 2120 NO 2Dd ACC DENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I ar Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Day, Year Haur a.m. 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stole) Not While factory, street, affice bldg., etc.) at wark at work 21. Iscartify that (1) (this hospital) attended the desegsed from Tune , 1961, ta Kua Zo, 1961, that (1) (we) last director, page 3 should should be filed with the 196 and that death accurred at_____ _M, fram causes and an the date stated above. FUNERAL DIRECTOR: saw the deceased alive an_ 22g SIGNATURE 22b. DATE SIGNED 8/20/67 DIRECTOR M.D. 224 Ampress Old Balt. Rd., Olney, Md. 22c PHYSICIAN S Yates Richard NAME (Type) 236 DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BURIAL CREMATION. (State) (County) REMOVAL (Specify)
Burial 8/22/67 Suitland, Maryland Cedar Hill Funeral Home-1331 Rockville Pike ALIC 9 25b. REGISTRAR'S SIGNATURE incliarles DATE AUG Rockville, "aryland



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11.365 PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death fulleral Land 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH Maryland b. COUNTY Montgomery o. STATE o. COUNTY Montgomery MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ve carban papers. Pages event, within 72 haurs aft b CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 write RURAL and give nearest town) Bethesda Kensington filled in I d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ON A FARM? 4715 Rosedale Ave. Carroll Hall Sanitarium NO 4 DATE NAME OF Middle First Lost Year DECEASED Elizabeth Shoemaker Aug. 67 Florence (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS 9. AGE (In years S SEX 6. COLOR OR RACE 7. MARRIED 8. DATE OF BIRTH NEVER MARRIED dve lest surthday) Dovs Hours 12-20-84 White Female WIDOWED 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Recurred Food Mgr. 12 CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) INDUSTRY Montgomery 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Mollie Wilson Amos W. Magruder Addinson 17th Ave. 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16, SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service 577-18-4492 Carroll W.Shoemaker Adelphi. Md. 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c))
PART I. DEATH WAS CAUSED BY INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate cause (o), DUE TO stoting the underlying couse by the haspital ar aftending 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA, DISEASE CONDITION GIVEN IN PART 1(0) State Dept. af Health NO After this certificate ā 20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18) 20o ACC DENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (City or town) (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d INBURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) Hour 'o.m. foctory, street, office bldg., etc.) Not While of work 2). I certify that (I) (this haspital) attended the deceased from Aug. O HOSPITAL OR ATTEND Page 4 may be retained 19 () and that death accurred at G 200 M, from causes and on the date stated above TO FUNERAL DIRECTOR: saw the deceased alive an. 22b DATE SIGNED 220 SIGNATURE STAFF PHYS Aug.4, 1967 M.D. 22d ADDRESS 4801 Montgomery 22c. PHYSICIAN HERMAN JOHN Bethesda. Maryland 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 230 BURIAL, CREMATION. 23b. DATE THEREOF (County) REMOVAL (Specify)
Burial Bethesda, Maryland Mt. Zion Cemetery 250. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR Bethesda. VR A15 (4)



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11305 CERTIFICATE OF DEATH 11306 requires that the death certificate be executed within 24 hours after death. completely filled in by the funeral rove carbon popers. Pages I and by every, within 72 haurs ofter deat PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY Montaomeru MARYLAND Montgomery b. CITY OR TOWN (if autside carparate limits, write RURAL and give nearest town) ¿ LENGTH DE STAY IN 16 c CITY OR TOWN "It autside carparate limits, write RURAL and give nearest town) Dakoma Park months d. STREET ADDRESS e IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) 7620 Manle Avenue NO DO Washington Sanitarium and Hospital NAME OF 4. DATE Last Manth Day Year (Type or print) OF DEATH Angust 1967 IF UNDER I YEAR IF UNDER 24 HRS AGE (In years last birthday) 5 SEX 8. DATE OF BIRTH 6. COLOR OR RACE 7 MARRIED **NEVER MARRIED** Manths Days Hours White Male WIDOWED DIVORCED March 19 1908 гел the ottending physicion and set permit. Then please rem in of 10a JSUAL OCCUPATION (Give kind of work done 11 BIRTHPLACE (County & State, or foreign country) 10b K ND OF BUSINESS OR 12 CIT-ZEN OF WHAT during mast af warking life, even if retired) INDUSTRY Washington D.
14 MOTHER'S MAIDEN NAME Mechanic tomobile. 13. FATHER'S NAME signed by the ottending physi burial-transit permit. Then pl burial, cremation, or removal, Grances Mc Coy Shoemaker 17 INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 7620 Maple Avenue (Yes, na, ar unknown) (If yes give war ar dates of service Ruby A. Shoemaker Jakoma Park. Maryland 577-10-3678 Ues INJERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a) PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Canditions, if any, which gave rise to immediate cause (a), DHE TO stating the underlying cause os the prior to b hos been last PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING AD DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY detached for use of PERFORMED? NO by the hospitol or TO FUNERAL DIRECTOR: After this certificate 20g ACCIDENT WAS UNDERLYING □ 205. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c. TIME OF INJURY Manth, Day, Year Haur a.m. 20d. INJURY OCCURRED factary, street, affice bldg., etc.) Nat While at work at wark should be 1962, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased fram. Poge 4 may be retained director, page 3 should should be filed with the and that death accurred at D. A. Aram causes and an the date stated above saw the deceased alive on. 22a. SIGNATURE 22b. DATE SIGNED **ATTENDING** DIRECTOR PHYS. MD. PHYS. 22d. ADDRESS Silver Spring 22c. PHYSICIAN'S University Blud. NAME (Type) ¿ast. Kenneth 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23g. BURIAL CREMATION 23b DATE THEREOF REMOVAL (Specify) Falls Church, Virginia National Memorial Park 25b. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR FUNERAL DIRECTOR Milianley VR A15 (4) 20 M 1/66 lohn. one Silver Spring. 196 Funeral Home



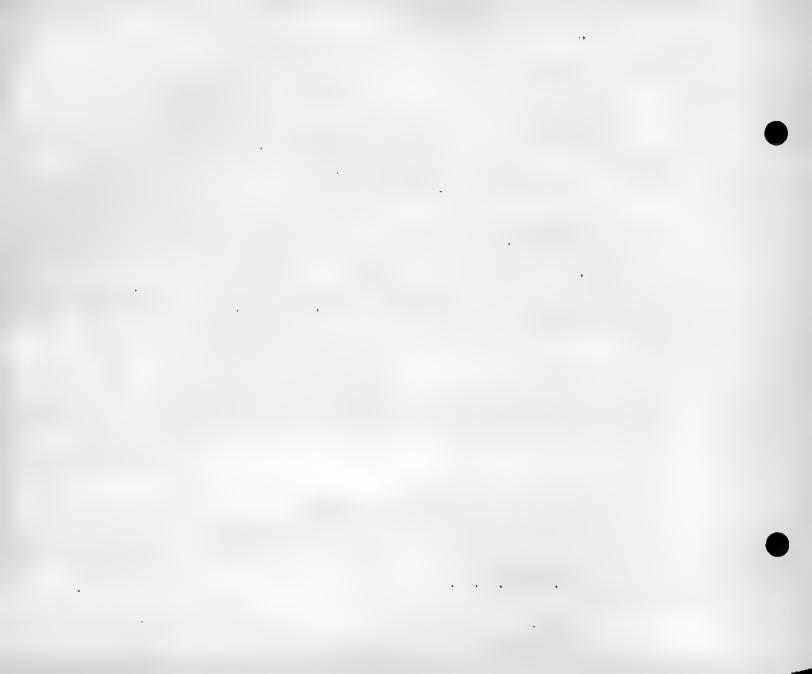
1,	PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Resource) 5. COUNTY 5. COUNTY
	I want on Elymanyland no
Bu.	b. CITY ON TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY ON TOWN (if outside corporate limits, write RURAL and give negrest town)
15	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give stream eddress) d. STREET ADDRESS
16	So I Coul Part Home. Schlich Strauther 1/Mali
3.	NAME OF First Middla Last Last Month OF OF TOTAL
L	(Type or print) anah S. SHERT DEATH & 25
5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH
10	2MA12 COL WIDOWED 3-6-180 / 80 yrs.
	6. USUAF OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CIU.
13.	FATHERIS DAME 14. MOTHER'S MAIDEN NAME
	George Slye Inknown
15. (Ya	WAS DECEASED EVER IN U.S. ARMED FORCES? S. SOCIAL SECURITY NO. 17. INFORMANT Address Address
	KECOLO - Frankful Krot
	18. CAUSE OF DEATH (Entar only one causa per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) FULL MANUALLY EDGENOLULI FOR THE PROPERTY OF TH
	DUE TO A
	Conditions, if any, which ? (b) Myscartia Fataction
	gave rise to immediate cause (a), stating the undarlying DUE TO
	cause lest. (c) Antuno Sclar Oos
CERTIFICATION	PART II OTHER SYSNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART
TEICA	20e. ACCIDENT WAS UNDERLYING 20b. DESCRIBE FOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Itam 18.)
CER	OR CONTRIBUTING CAUSE OF DEATH (IF SITHER, NOTIFY MEDICAL EXAMINER)
WEDICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20s. PLACE OF INJURY (Home, farm, 20f. (City or town) (Cour Hour a.m. Whila Not While factory, strast, offica bldg., atc.)
WED	Hour a.m. While Not While at work tactory, stream, onice bldg., etc.)
	21. I certify that (I) (this hospital) attended the deceased from 1966 to 1966 to 1966.
	saw the deceased alive on
	122. SIGNATOR OF THE STAFF AND. ATTENDING MED. STAFF PHYS. DIRECTOR PHYS.
	22c. PHYSICIAN 5 NAME (Not)
_	1 202 /1417X 41, 2004
23	TRETOVAL (Spacety)/ 9/00/00/00/00/00/00/00/00/00/00/00/00/00
74	FUNERAL DIRECTOR'S SIGNATURE ADDRESS ADDRESS ADDRESS ADDRESS ADDRESS DE REGISTRAR 256. REGISTRAR 256. REGISTRAR'S, S
40	7// 050 1 1907 17/00/0
-	LONE 16 / hunden - Lack valle onSEP 1 1967 Cliante



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11308 CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. COUNTY **B** COUNTY b. CITY OR TOWN (If ourside conscrete limits, write RURAL and give nearest town) aruland MARYLAND nontermens c LENGTH OF STAY IN 16 c. CITY OR TOWN existe carporate limits, write RURAL and give nearest town) *.E d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS B IS RES DENCE ON A FARM2 20 within YES NO D NAME OF Middle DATE Last Year campletely Day DECEASED and in any event, (Type or pnnt) mrs magge ē DEATH The law requires that the death certificate be executed 6. COLOR OR RACE / AGE (In years IF UNDER 24 HRS C. MARRIED IF UNDER I YEAR **NEVER MARRIED** DATE OF BIRTH last birthday) Months Days Hours WIDOWED DIVORCED and 10a JSUAL OCCUPATION (Give kend of work done 10b, KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT physician c during most of working life, even if retired) INDUSTRY rarulan 7-Lorise W 13 FATHER'S NAME 14 MOTHER'S MAJEEN NAME burial, crematian, ar remaval, WAS DECEASED EVER IN ILS ARMED FORCES? 37 INFORMANT 16. SOCIAL SECURITY NO (Yes, na, ar unknown) (If yes give war ar dates of service) 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) INTERVAL BETWEEN signed by the burial-transit p PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) be retained by the haspital ar attending physician. 4221 DUE TO Canditians, if ony, which gave rise to immediate couse (a). **DUE TO** stating the underlying cause as the Health priar to has PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT WAS AUTOPS PERFORMED? YES NO/ 20g ACCIDENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I at Part II of item 181) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, form, 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (State) (City or town) (Caunty) Haur 'a m. factory, street, affice bldg., etc.) Not While 19 of work FUNERAL DIRECTOR: After 21. I certify that (I) (this haspital) attended the deceased fram. 3 should twith the S and that death occurred at 3 :65 Am saw the deceased alive an causes and an the date stated above 22a SIGNATURE 22b. DATE SIGNED ATTENDING director, page 3 should be filed w M.D. DIRECTOR PHYS. PHYS. 22c. PHYSICIAN S 22d ADDRESS Page 4 may NAME (Type) e23d +DCATION (City or Town) 23a, BURIAL, CREMATION 23b DATE THEREOF 23c. NAME OF CEMETERY OR GREMATORY (State) REMOVAL (Specify) 2 24 FUNERAL DIRECTOR VR A15 (4) 25M 1/67



	-1		11309	_DIVISION Item #2	M. OF VITAL R	ARYLAND ST ECORDS, 301 1 & d Film CFRT	ATE DEPA W. PRESTO	ARTMENT OF HEADN STREET, BALTIMO	LTH ORE, MAR' h & I	YLAND 21201 tem #7	113	10	
-++	deoth and 2	Ī	PLACE OF DEATH o. COUNTY MONT	rgomery		 		2. USUAL RESIDENCE (V	Vhere deceos	ed lived, if institut	on Residence	pefore odmissi	on)
	4 hours offer deat in by the funeral ers. Pages 1 and 72 hours offer deat	1	b. CITY OR TOWN (If ou write RURAL and giv	tside corporate limite e nearest tawnRIII	RAL	c LENGTH OF STA		CITY OR TOWN (If ou		te limits, write RUF	Act and give no	ams corest town)	
	in 24 hours of filled in by the footbars. Pagint 72 hours	F	Bethesd d. NAME OF HOSPITAL O US NAVAI		it in hospital, g	54 da (ive street oddress)	ays	Nokonas d sireer address / Proute 124/:	Gett ,/203 Box/1/0	Hanover	St.	B IS RESTI	
	completely fill nove to room within		NAME OF DECEASED (Type or print)	RALPH"		WALDO	SI	TLER	4. DATE OF DEATH	AÚG'			^{lor} 67
	e execute and comp remove n ony eve		MALE	CAUC	7. MARRIED / WIDOWED	DIVOR		DEC 21 1907	9	AGE (In years destricted birthday) yrs.		ys Hours	R 24 HRS. Min
	ate be icion an lease re ond in	ฉีย	Pormer Sta	te kind of work done	10b. KI 1N	ND OF BUSINESS OF DUSTRY		1). BIRTHPLACE (County Berwick,	Penns		12 CITIZE COUNT	N OF WHAT IRY? US	SA
	certific ng phys Then p		Joseph H.	Sitler		OCIAL SECURITY NO		14. MOTHER'S MAIDEN N	norr				
	e deoth ottendii on, or re	(Ý) ===	WAS DECEASED EVER IN es no, or unknown) (If your			176 07 83	339 M	nformant Berwirs. Esther M	ick, F 1. See	ennsylvæ ly, 631	nia East l	th Str	reet
	law requires that the death certificate be executed within 24 hours ofter death anding physicion. been signed by the ottending physicion and completely filled in by the funeral street but and the burial-transit permit. Then please remove corbon papers. Pages 1 and it to burial, cremation, or removal, and in any event, within 72 hours after death in the burial cremation.		18. CAUSE OF DEATH W	DUE		(0), (b) and (c)) Metasta	tic Ca	rcinoma Blac	lder			ONSET AND D	
	OR ATTENDING PHYSICIAN: The law requires the be retained by the hospital or attending physicion. DIRECTOR: After this certificate has been signed by ge 3 should be detached for use as the buriaf-trailed with the State Dept. af Health priar to burial, cre-		Conditions, if ony, whi rise to immediate co stating the underlyin- lost,	use (a), g couse DUE			· · ·						
	TO HOSPITAL OR ATTENDING PHYSICIAN: The law repoge 4 may be retained by the hospital or attending 100 FUNERAL DIRECTOR: After this certificate has been staretar, page 3 should be detached for use as the beshould be filed with the State Dept. af Health priar to be	Dest. Color Part II Other Significant conditions Contributing to death but not related to the terminal disease condition given in Part I(o) The terminal disease condition given giv								19 WAS ALTO PERFORM YES X	OPSY NO		
	PHYSICIAN: The e hospitol or other his certificate hos stacked for use a Dept. af Health pr										(45)		
	NG PHY y the ho er this e e detacl ate Dep	MEDICA	2Dc. TIME OF INJURY Hour 'o.m. p.m.	19	While of work	JURY OCCURRED Not While of work	focto	E OF INJURY (Home, form ory, street, office bldg., etc.)		(City or town)	(County	,	(State)
	OR ATTENDING be retained by it IRECTOR: After it e 3 should be d ed with the State		21. I certify the saw the decea	hat (I) (this hosp sed alive on	oital) attend	ed the decease	od from_J , and that	death accurred at	9 67 to	AUG 22 , from causes o	and on the		abave
	IL OR A y be ret DIRECT oge 3 stilled with		22c. PHYSICIAN'S	12.10	166		M D	ATTENDING PHYS 22d, ADDRESS	MED DIRECTOR	STAFF PHYS 🗷	223 A	igust]	1967
	O HOSPITAL Page 4 may O FUNERAL I director, pag should be fill	230	NAME (Type)	H. Rives,		23c NAME OF C	EMETERY OR C			1, Bethe			itote)
	VR A15 (4) 25M 1/67	2	REMOVABLE SPECIFICAL TO THE PROPERTY OF THE PR		/1967	Evere Home	green (Cemetery 250 RECD		tysburg.		lvania	3
	25M 1/67		Gettysburg	Pennsyl	vania		le 1 Mas	King Va DATE	~ 0 I	NE 311 1	434	A WE DONE	in .



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11309 11309 CERTIFICATE OF DEATH TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Paath certificate be executed earthin 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased aved, if institut an Residence before admission) the funeral a COUNTY Montgomery o. STATE b. COUNTY MARYLAND Maryland b CITY OR TOWN (If outside corporate limits, c CITY DR TOWN (If outside carparate limits, write RURAL and give nearest town c LENGTH DE STAY IN 16 write RURAL and give nearest town) 36 days Baltimore Bethesda d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address)2007 / d STREET ADDRESS S RESIDENCE ON A FARM? The Clinical Center, Bethesda, Maryland 3814 Moravia Road NO IX NAME OF Middle 4. DATE Month DECEASED Mildred Regina Simpson August (Type or print) DEATH 67 S SEX 8 DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR F UNDER 24 HRS 6 COLOR OR RACE 7. MARRIED NEVER MARRIED last birthdoy) Days Hours White Famale 21 July 1917 WIDOWED DIVORCED [10a USUAL DCCJPATION (G-ve kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT INDUSTRY WIN Home COUNTRY? physician (ien please during most of warking life, even if retired) Maryland 14. MOTHER'S MAIDEN MELdred 13. FATHER'S NAME John Taylor Tracey Amelia/Pfaff 16 SOCIAL SECURITY NO. 17 INFORMANT The Medical Recoradress 1S WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, ar unknown) (If yes give war ar dates of service) 220-14-6108 The Clinical Center, Bethesda, Maryland 2001 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY INTERVAL BETWEEN signed by the burial-transit p 90NELAND DEATH Cerebral embolus IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave use to immediate cause (a), Atrial thrombosis & calcification vears DUE TO stating the underlying cause certificate has been () Rheumatic Heart disease 40 years WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTR.B. TING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Bronchopneumonia YES X NO 20a ACCIDENT WAS UNDER, YING □ 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Gc TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (City or town) (County) (State) Nat While factory, street, affice bldg., etc.) at work 21. I certify that (1) (this haspital) attended the deceased from July 17 , 19 67, to August 2219 67, that (1) (we) las saw the deceased alive on August 22, 19 67, and that death accurred at 3:30 M, from causes and an the date stated above director, page 3 shauld should be filed with the TO FUNERAL DIRECTOR: SIGNATURE 22b DATE SIGNED 220 ATTENDING MED STAFF DIRECTOR PHYS ☑ 22 August 1967 22d ADDRESThe Clinical Center, National PHYS CIAN S NAME (Type) Institutes of Health, Bethesda, Md, 20014 Lynn M. Peterson, MD 23d LOCATION (City or Town) 23c NAME OF CEMETERY OR CREMATORY 23a BURIAL, CREMATION 23b DATE THEREOF (County) Pulaney Valley Mem. REMOVAL (Specify) 8-23-1967 Timonium, Balto . Co., Md. 250 REC'D BY REGISTRAR ,24 FUNERAL DIRECTOR ULTER Wisc DC DATE Inc. N. Sons,



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11311 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 haurs after death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) D. COUNTR PN tyom or MARYLAND c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) CITY OR TOWN III outside corporate limits. write-RijRAL and give negrest town! hin 72 haurs filled in by Komp d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? NO 1 NAME OF Middle DATE Lost Month Dov Year DECEASED (Type or print) DEATH S. SEX IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED iost burthdow Months Doys yno ni buo WIDOWED DIVORCED 10o USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BUCTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) DANTRYS Retired 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remaval, IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16 SOCIAL SECURITY NO. Address (Yes, no, or unknown) (If yes give wor or dotes of service) crematian, 18. CAUSE OF DEATH (Errer only one couse per line for (o), (b), ond (c).
PART I DEATH WAS CAUSED BY. INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (a) signed by DUE TO Conditions, if ony, which gove nse to immediate couse (a). DUE TO stating the underlying couse has been s Inst WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for Use Health NO E this certificate 21 206 ACCIDENT WAS UNDERLYING [1] DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port for Port II of item 18) O HOSPITAL OR ATTENDING PHYSICIAN Page 4 may be retained by the haspital OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2De PLACE OF INJURY (Home, form, 2Dc TIME OF INJURY Month, Doy, Year 2Dd INJURY OCCURRED (Eity or town) (County) (State) Hour 'o.m. foctory, street, office bldg., etc.) Not While ot work of work 21 I certify that (I) (this haspital) attended the deceased fram . 19 6 7 that (1) (we) last 19 67, and that death accurred at 3 2 am, from causes and an the date stated above. O FUNERAL DIRECTOR: saw the deceased alive an 220 SIGNATURE 22b. DATE SIGNED M D DIRECTOR director, page should be filed 22d. ADDRESS Conn. Ave. 22c. PHYSICIAN'S NAME (Type) BLOEMSMA Chase. BURIAL CREMATION 23b DATE THEREO NAME OF CEMETERY OF CREMATOR) 23d LOCATION (City of Jown) (Stote) REMOVAL (Specify) lnir 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67



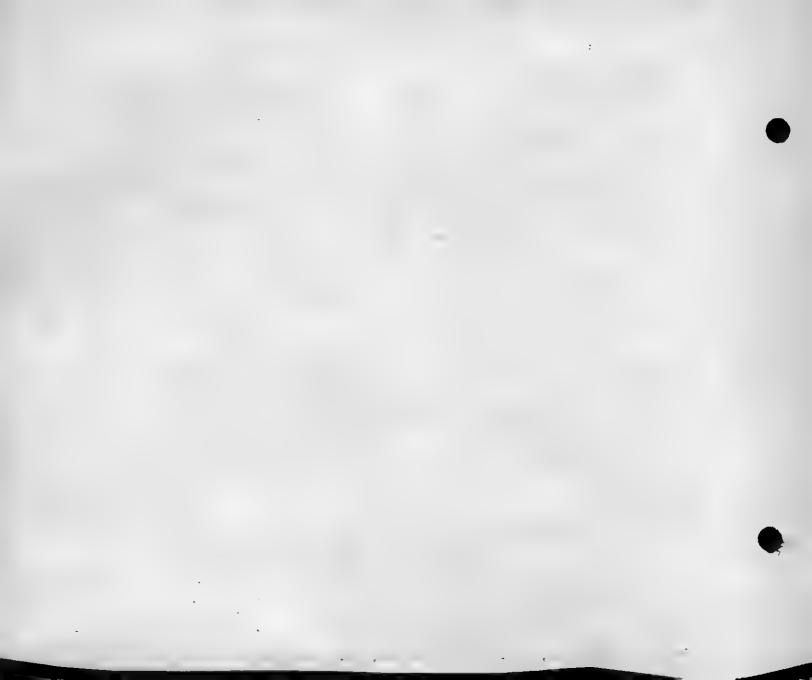




MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11514 11313 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased fived, if institution. Residence before admission) o. COUNTY. **B. COUNTY** moni gemery MARYLAND COLTY OF TOWN outside carparate Emits, c LENGTH OF STAY IN 16 ate limits write RURAL and give negrest town) write RURAL and give nearest town) illed in papers. d. STREET d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **ADDRESS** e IS RESIDENCE ON A FARM? within 72 filled i YES NO NAME OF First 4. DATE Last Month Year Day DECEASED OF Ъ (Type or print) DEATH 196 and complet S SEX 6. COLOR OR RACE 7 MARRIED DATE OF BIRTH AGE (In years LE LINDER 1 YEAR IF UNDER 24 HRS **NEVER MARRIED** [birthday] مost السير Months Dovs Hours WIDOWED DIVORCED w. IDo USUA: OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY. and physican en please MILK SALFSKEL 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME ar remayal. Arthur Smith Sarah Marie Stanley 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMAN (Yes, ng, or unknown) (If yes give war or dates of service cremation, 18. CAUSE OF DEATH (Enter only one couse per line for al-transit PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o' by the haspital ar attending physician. DUE TO signed bur al-tr bur al-tr burial, c Conditions, if ony, which gove nse to immediate couse (a). DUE TO stating the underlying couse as the priar to lost. 19 WAS AUTOPSY PERFORMED? has PART 1º OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA, DISEASE CONDITION GIVEN IN PART 1(a) Health p NO. 200 ACC DENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port II of item 18.) OR CONTRIBUTING ELECAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Year 2Dd INILIRY OCCURRED 20e PLACE OF INJURY (Home, form, (Stote) (City or town) (County) Hour o.m. factory, street office bidg, etc.) While Not While of work at work 196 , that (I) (we) last 21. I certify Mat (1) (this haspital) intended the deceased from be retained accurred at & P DIRECTOR: and that death M, from causes and an the date stated above saw the decased alive an 22g SIGNATI ATTENDING DIRECTOR PHYS PHYS page e filed 22d. ADDRESS Page 4 may FUNERAL director, p 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION, 23d. LOCATION (City or Town) (County) 8-5-67 Jersey City Jersev City 0 24. FLINERAL DIRECTOR REC'D BY REGISTRAR REG STRARS SIGNATURE VR A15 (4) 25M 1/67



1	MARYLAND STATE DEPARTMENT OF HEALTH
Secretary to the second	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
	CERTIFICATE OF DEATH
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letely pers.	3. NAME OF FIRST Middle Last 1 DATE Month Day Year
ecut pap	(Type or print) JEANETTE MARY STANISH DEATH NUGUST 8 1967
S COL	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years) FUNDER LYEAR; IF UNDER 24 HRS.
e be	WIDOWED DIVORCED MARCH 5, 1986 61 yrs. Hours Min.
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the ath The The Oval	(Yes, no. or unkown) (Hyesgivewerordelasofservice) NONE. MR. NORMAN GENARO - 7219 Takoma Pak, MD
Sa fa	18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c)
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TING d by After ache	ZOc. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm, 20f. (City or lown) (County) (Stele) Hour a.m. While Not While st work at work at work at work
S. det	p.m. 19 st work at work
Det Det	21. I certify that (I) (this hospital) attended the deceased from 12.7
ista de la constante de la con	saw the deceased alive on. 14.51919
C 12 0	STAFF DIRECTOR PHYS. D DIRECTOR PHYS. D QUALLET STAFF
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SPIT Pag NER Or, Pe	HAROLD W. DRAPER 911 SILVER SPVING AVE, MI.
Hearing St.	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, fown or county) (51ete)
040 44 A	Burial Ang 11, 1967 Fort Lincoln Cemetery Prince Georges Co. Md.
VR A15 (4)	C. Glen Earter, Men (24) 4 Georgia Avenue ALIC 1 1 1967 Ochander Judge
100	Warner E. Pumphrey, Inc. Silver Spring, Md. DATE AUG 14 1301



.1		MARYLAND STATE DEP		
-		AL RECORDS, 301 W. PRESTO	ON STREET, BALTIMORE, MARYLAND 21201	5 5 6 6
· FOR STATE	11315 N	MEDICAL EXAMINER'S	CERTIFICATE OF DEATH	1_316
HEALTH, DEPT.	D PLACE OF DEATH O. COUNTY		2. USUAL RESIDENCE (Where deteosed lived, if institution	
Page 15	IIION T.	MARYLAND	o. STATE Md. b COUNT	Mont,
dela ind 3 13 P	b CITY OR TOWN (If autside carporate mints, write RURAL and time nearest town)	C LENGTH OF STAY IN 16	c. C TY OR TOWN (If our side corporate limits, write RIRA	(L and give nearest town)
f c y delay is 1, 2, and 3 to PM3 Page.	d NAME OF HOSP TAL OR INSTITUT ON (If not in hosp		d. STREET ADDRESS	A IS RESIDENCE
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State State	3 NAME OF First	/ Middle	_ast 4 DATE Worth	Day Year
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hin 24 hours after c ncd in Item 18. G.ve niner's Office alang v pages land 2 with th urs after death.	S SEX 6. COLOR OR PACE 7. MAR		B. OATE OF BIRTH 9 AGE (n years lost b rindon)	Months Doys Hours Min
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within pencul Examines File page	Samuel Staub, Sr.		Helen Hawes	
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e executed pending" ir of Medical I sit permit. It within 72	NO 1B CAUSE OF DEATH (Enter only one couse per in		elen Staub	INTERVA, BETWEEN
be e "per lief / ant v	PART I DEATH WAS CAUSED BY MMEDIATE CAUSE (o)	ksanguination		SNSET AND DEATH
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This certificate should icate, writing the ward be farwarded to the Classical and any every care in any every removal, and in any every				PERFORMED? YES TO NO
MEDICAL EXAMINER: This please execute the certificate, director Page 4 shauld be faretained far yaur files. DIRECTOR: Page 3 shauld be to the plant of the plant	200 EXTERNAL CAUSE WAS PRIMARY OF OF CONTRIBUTING CAUSE OF DEATH		(Enter nature of njury in Part I or Part I of Item IB)	
MINER: the certif 4 shauld ur files. e 3 shaulc natian, or		Pressenger in C	(E OF NJURY (Home form 20f ((ty or town)	(County) (State)
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ease firect firect taine ta b	ACTUAL O 0	. B. 10	CHIEF MEDICAL EXAMINER	22. DATE SIGNED
N Pl	SIGNATURE farm	1 1 3 3 4 4 4	M D ASSISTANT MEDICAL EXAMINER [] DEPUTY MED CAL EXAMINER []	29/67
necessary, please execute the certificate, writ the funeral director Page 4 shauld be farwar 5 may be retained far your files. To FUNERAL DIRECTOR: Page 3 shauld be used Health priar to burial, cremation, or removal,	NAME (Type) JOHN G.		Address (Street, city, town, or county) Be	
D E E	230 BURIA., (REMATION 23b DATE THEREOF PEMOYA) (Specify)	23c NAME OF CEMETERY OR		
- F	Burial 8-31-67	Parklawn	Cemetery Rockville	Maryland ISTRAR S SIGNATURE
VR A15ME (5) 6M 1767	ROBERT A. PUMPHREY,	Bethesda, Mary	rl and	
			Tand DATAUG 3 1 1967 70	Careley Judge



	MARYLAND STATE DEPARTMENT OF HEALTH
	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 1128 CERTIFICATE OF DEATH
	1. PLACE OF DEATH. 1. 2. USUAL RESIDENCE (Where deceased I ved, it institution: Residence before ad
	a. STATE MOLLA 1 b. COUNTY MOLA
	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town
	WASITING TON GROVE 31 Washington Grove, Md.
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address) d STREET ADDRESS a. IS RES
	404 Chestnut Street YES 1
3.	NAME OF First Middle Last 4. DATE Month Dey Year DECEASED OF
	(Type or print) Georgie Cornelius Swann DEATH & 22 196
C. P.	6. COLOR OR RACEO, MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 2 Iest birthday) Magnits Days Hours
	11 016 MILLS MIDOMED DIVORCED 1464, 54, 1848 64 Aug. 3 53
	106. USUAL OCCUPATION (Give kind of work done during most of working life, even if relired) 106. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & Stete, or loreign country) 12. CITIZEN OF WHAT CO
	Steam Engineer - Wayland USA 13. FATHER'S NAME 14. MOTHER'S MADEN NAME
I	Go. T. C.
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address
	(Yes, no, or unkgwn) (Ilyasgivewarordelesofsarvice) 213-10-7804 ERNEST J SWANN - WASH. GROVE, ML
ĺ	18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] [INTERVAL BETT ONSET AND D
l	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) DELLIS IMPONÉE A CAUSE (1)
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	Conditions, if eny, which (b) Cancinnamia through
ĺ	(e), sleting the underlying DUETO
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ĺ	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (18) 19. WAS A PERFO
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ı	21. I certify that (I) (this hospital) ettended the deceased from
	saw the deceased glive on
l	22a. SIGNATURE ATTENDING MED. STAFF 22b
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	13 Deer Park Dr. Gaithersburg m.D. 13 Deer Park Dr. Gaithersburg m.
١	236. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, lown or county) (5h
Į	REMOVAL (Specify) 1/21/67 Parklaun Cemetery Rockille Wid
۱	24 FUNERAL DIRECTOR'S SIGNATURE 258. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE
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1		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND
= =0=		11318 CERTIFICATE OF DEATH
death. funeral V and 2 r death.	1.	PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission,
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77 一直 11		UNASHINGTON SANITARIUM + HOSPITAL 641 HOUSTON AVE 9. IS RESIDENCE ON A FARM? YES NO MO
coupletery ve carbon p event, within	3.	NAME OF MIDDE First Middle Last 4. DATE Month Day Year
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nte be executed w	3	Finale Whate WIDOWED DIVORCED 7/10/1903 last birthday) Months Days Hours Min.
be ecial	10a dur	USUAL DECUPATION (Give kind of work done Industry) 10b. KIND OF BUSINESS OR INDUSTRY:
ohysi ple al, a	13.	FATHER'S NAME COUNTY KILDRAY TENN. 14. MOTHER'S MAIDEN NAME
ertific		WILLARD A. EISEMAN MOZELLE CONNOLLY
law requires that the death certificate be of the finding physician. The line signed by the attending physician is as the burial-transit purmit. Thun please prior to burial, cremation, or removal, and in	15 (Ye	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITYNO. 17. INFORMANT Address. 16. SOCIAL SECURITYNO. 17. INFORMANT (If yes give war or dates of service) 25-22-9763 TIMOTHY W. TESTER (Same at \$2.)
he d y te sit p matic		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSE AND DEATH
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ling ulling ulli		gave rise to immediate cause (a), stating the DUE TO
ttenc thas has as as prio	N.	underlying cause last.) (c)
The cate ruse eaith	ICATI	YES NO
PHYSICIAN: The la the hospital or att tills certificate h detached for use detached for use ce Dept. of Health p	CERTIFICATION	20a. ACCIDENT WAS UNDERLYING () 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of Item 18.) DR CONTRIBUTING () CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
HYS the h this letag	MEDICAL	20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State)
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C 0 4 70		21. I certify that (I) (this hospital) attended the deceased from Addy 6, 1967, to Addy 1, 1967, that (I) (we) las saw the deceased alive on 1967, and that death occurred at 657M, from the causes and on the date stated above
OR ATT be ret be ret liRECTI		228. SICNATURE / 22b. DATE SICNED
SPITAL 0 4 may b 11 mill 01 tor, page d be filed		22c. PHYSICIANS 22c. PHYSICIAN
TO HOSPITAL OR ATTENI Page 4 may be retaine O FUNIETE DIRECTOR: director, page 3 should should be filed with the		AETER H. OROLL HAW 40 1106 SILVER STRING NO.
Par direction	.23a	Burial aug 16.1967 Oaklaum Cimiting Carbondale Illinois
VR A15 (4)	2ª	FUNERAL DIRECTOR 254 Carroll ALMU WALL TOTALG 1 5 1967 ACharles Indge
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in grade to 3.

Me Great H. Reliense.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #14 Film #3221 7 DR CERTIFICATE OF DEATH 11319 PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) · COUNTY MONTGOM & R MARYLAND b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) papers Po hin 72 hauh 2 months Sandy Springs d STREET ADDRESS e IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Earnshaw Apartments YES NO DO NAME OF Middle 4. DATE Month Doy Year DECEASED OMPSON 1967 eve carl (Type or print) AGE (n years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 6 COLOR OR RACE DATE OF BIRTH 7 MARRIED NEVER MARRIED Days Hours WIDOWED DIVORCED rem and burial, cremation, or removal, and in or 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRYS FATHER'S NAME 14. MOTHER'S MAIDEN NAMI Phiscilla/Richardson/ Eugenia Merriken William B. Hardesty WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT 3404 Rolling (Yes po, or unknown) (If yes a ve war or dates of service PART DEATH (Enter on y one couse per line for (o), (b) and (c)) fransit ONSET AND DEATH IMMEDIATE CAUSE (a) TO HOSPITAL OR ATTENDING PHYSICIAN: The faw réquires that Page 4 may be retained by the haspital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by DUE TO signed L Metastatic corceroma of the endometrum Conditions, if any, which gove rise to immediate couse (a), DUE TO stoting the underlying couse as the priar to b last WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FERMINAL DISEASE CONDITION GIVEN IN PART 1(6) NO 206 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of Jern 18) 200 ACCIDENT WAS JNDERLYING [OR CONTRIBUTING CAUSE OF DEATH 3 shauld be detached with the State Dept of (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or fown) (Stote) 20c TIME OF NURY Month, Day, Year Hour o m (County) Not While factory, street, office bida, etc.) at work of work 21. I certify that (1) (this hespital) attended the deceased from Dec 19/0 6 ta Other 2 - 19 4 / that (1) (wa) last saw the deceased alive on July 30, 1967, and that death occurred at \$ 30 A M, from causes and an the date stated above. 22o. SIGNATURE 22b. DATE SIGNED MD DIRECTOR 22d ADDRESS 22c PHYSIC AN S 5000 NORbELL NAME (Type) Rou Wagstaff 23c NAME OF CEMETERY OR CREMATORY 23b DATE THEREOF 23d LOCATION (Chy or Town) (Store) 23a BURIAL CREMATION. (County) REMOVAh (Specify) Toy Hill Cemetery Alexandria, Virginia 2So. REC'D BY REGISTRAR VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201. 11320 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. STATE P COUNTY b CITY OR TOWN (If outs de corporate/lip C LENGTH OF STAY IN 15 c CITY OR TOWN (If outside corparate limits, write RURAL and give negrest town d STREET ADDRESS (INSTITUTION (If not in hospital, give street address) e IS RESIDENCE ON A FARM? NO X NAME OF Middle 4. DATE Last DECEASED (Type or pnnt) vent, DEATH SEX IF JNDER I YEAR IF UNDER 24 HR AGE (In years lost withday) **NEVER MARRIED** Days Hours WIDOWED DIVORCED 10o JSUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life, even if retired) 13. FATHER & NAME 14 MOTHER'S MAIDEN MAME 16 SOCIAL SECURITY NO INFORMANT (Yes, no or whknown) lift yes give wor or dates of service) IB CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY. Babelism, massive, pulmenary artery IMMEDIATE CAUSE (6) DUE TO Cardiac arrhythmia 2 days Conditions, if any, which gave (b) rise to immediate couse (o), DUE TO stoting the underlying couse has been the Mural thrembus, right auricle due te ceronary 2 days PHYSICIAN: The low WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) (400 lbs) and early hypestatic branchepneumonia Obesity, marked YES T NO J O FUNERAL DIRECTOR: After this certificate 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) 20o ACCIDENT WAS UNDERLYING [7] OR CONTRIBUTING I CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Not White factory, street, office bldg., etc.) OR ATTENDING 21. I certify that (1) (this haspital) attended the deceased from MANCH, 1955, to PRESER be retained 3 / 1967, and that death accurred at 10 A M, from causes and on the date stated above saw the deceased alive an_ 22o. SIGNATURE 22b. DATE SIGNED M.D DIRECTOR 22c PHYSICIAN'S 22d. ADDRESS O HOSPITAL NAME (Type) JR. 23c. NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION 23b DATE THEREOF 23d LOCATION (City or Town) (County) (Stote) B REMOVAL (Specify) Gate of Heaven Cem. 9-5-67 Silver Spring. Marylan d ADDRESS 2So. REC'D BY REGISTRAR 25b REGISTRAR S SIGNATURE 24 FUNERAL DIRECTOR PUMPHREY. Bethesda. Maryland 1967



STATISTICAL RESEARCH AND RECORDS. 301 W. PRESTON STREET, BALTIMORE 1. . PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Rasidence before admission) e. COUNTY b. COUNTY MON/GOMERY ihe 12 MARYLAND outside corporete I m Is, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS street address) e, IS RESIDENCE ON A FARM? 150 YES NO completely NAME OF DATE Traman Thillima DECEASED OF Ba (Type or print) DEATH HUMBA 19 carbon AGPIn yeers 6. COLOR OR RACI 8. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED TNEVER MARRIED last birthday) WIDOWED DIVORCED IDe. USUAL OCCUPATION (Give kind of work 1Db. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY done during most of working life, even if retired? 13. FATHER'S NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a , b), and (c), ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO Conditions, if any, which (b) gave risa to immediate causa DUE TO (a), stating the underlying causa last. PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(e) 19. WAS AUTOPSY PERFORMED? NO X 2Db. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part , or Part II of Item 18.) 2Da. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20d, INJURY OCCURRED, 2De, PLACE OF INJURY (Home, ferm, 2Df. (City or town) (State) (County) 20c. TIME OF INJURY Month, Dey, Yeer factory, street, office bldg., etc.) While Not While Hour a.m. et work at work saw the deceased alive on...... 22b. DATE 22e, SIGNATURE STAFF SIGNED ATTENDINGS DIRECTOR M.D. O HOSPITAL, death. Page 4 22c. PHYSICIAN NAME (Type) Francis J. Troendle Edmonston Dr. Rockville, Md. director, be filed (Stella) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23a. BURIAL, CREMATION, 23b. DATE THEREOF Forest Oak Gaithersburg, Maryland 6 OH hopels Rockville Piles. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) Rockville. Md. 15M 9/40

DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11322 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) CLENGTH OF STAY IN 16 e S RESIDENCE ON A FARM? YES NO Dep iot in hospital, q ve street address) d STREET ADDRESS farm 18 G've Pages be executed within 24 haurs after death be farwarded to the Chief Medical Examiner's Office along with NAME OF DATE OF DECEASED (Type or pant) DEATH 9 AGE (In years ost birthdoy) 7 MARRIED NEVER MARRIED Months Days and in any event within 72 haurs after death. DIVORCED WIDOWED in Item 10g USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT 16 SOCIAL SECURITY NO INFORMANT CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) NTERVAL BETWEEN PART I DEATH WAS CAUSED BY Head with Osphydia burial-transit Gon Shot wound 4 IMMEDIATE CAUSE for This cert ficate shauld certificate, writing the ward DUE TO Aspiratual blevol Conditions, flony which gove rise to immediate couse (a). DUE TO stoting the underlying couse 19 WAS ALTOPSY PERFORMED? PART I OTHER'S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA. DISEASE CONDITION GIVEN IN PART 1(a) ar remaval, YES A NO F 20o EXTERNAL CAUSE WAS 20b DESCRIBE HOW NURY OCCURRED (Enter nature of injury in Part I or Port II of item 8) 3 shauld PR MARY or CONTRIBUT NG shauld t Shot Sait in head, with 22 cal. Protel CALSE OF DEATH crematian, 20d JNJURY OCCURRED 20f (City or town) 20e PLACE OF NURY (Home, form (State) 20c TIME OF INJURY Month Doy, Year While of work I foctory, street, office bldg etc.) Gaithers buy Minto 21 I certify that I taak charge of the remains described above, held an Autapsy XI, Inspection , Inquiry 1 and in my apinian Natural causes Accident Suicide V. Hamicide Undetermined manner death resulted fram. be retained CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED SIGNATURE the funeral **EXAMINER'S** John G. Ball7936 Old Georgetown Road ov Bathasda, O FUNER Health 23d LOCATION (City of Town) 23b DATE THEREOF 23c NAME OF EMETERY OR CREMATORY Statel 230 BUR AT CREMATION 8/28/67 Park Head Cemetery Park Head Maryla LADORS ROCKVILLE PIREELD BY REGISTRAR 25b REGISTRAR S SIGNATURE 24 FLNERAL DIRECTOR VR A15ME (5)4 DATE AUG 28 1967 Tyson Wheeler Funeral Home Rockville, Md.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. COUNTY Montgomery b. COUNTY Maryland Montgomery MARYLAND b CITY OR TOWN (If outside corporate limits. c CITY OR TOWN (If autside corparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 write RURAL and give negrest town) OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours Bethesda Bethesda d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) .= d STREET ADDRESS e IS RES DENC filled ON A FARM? 5505 Charlcote Road 5505 Charlcote Road L. YES NO To NAME OF First Middle 4 DATE Last Month Dov Year completely DECEASED ELIZABETH TRICKETT (Type or print) event, DEATH Aug. SEX 6 COLOR OR RACE DATE OF BIRTH 9 AGE (In years IF LINDER 1 YEAR IF LINDER 24 HR 7 MARRIED NEVER MARRIED Manths lost birthdoy) Days Hours remay Apr. 13, 1888 White Female. WIDOWED DIVORCED pup 10b. KIND OF BUSINESS OR 1Do USUAL OCCUPATION (Give kind of work done 12 CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY? ottending physician sermit. Then please Penna. S lousewife 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME or removal, Phillip C. Swartv Helen 15 WAS DECEASED EVER IN ILS ARMED FORCES? 36 SOCIAL SECURITY NO 17. INFORMANT Husband Address (Yes no or unknown) (If yes give war or dates af service Same as Item 2. 157-18-6151 Thomas burial-transit pem burial, cremotion, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per lide for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY intractable IMMEDIATE CAUSE (o) DUE TO paugis Canditians, if any, which gave rise to immediate couse (o). DUE TO stating the underlying cause prior to by the haspitol or attending this certificate has been last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? Health | NO S 2Do ACCIDENT WAS UNDERLYING [1] 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d INIURY OCCURRED 20e PLACE OF INJURY (Harne, form, 2Dr. TIME OF INJURY Month, Day, Year (City or town) (County) (State) Haur 'a.m. While Not While factory, street, office bldg. etc.) ot work at work 21. I certify that (1) (this bospital) attended the deceased from linguist O HOSPITAL OR ATTEND Page 4 moy be retained august 12 P.M. from Causes and on the date stated above O FUNERAL DIRECTOR: sow the deceased alive an 196 and that death accurred at 4 220 SIGNATURE 22b. DATE SIGNED director, page 3 should be filed v MD DIRECTOR PHYS PHYS 22d ADDRESS 22c PHYSICIAN'S Wisconsin Ave. BLAINE NAME (Type) TYZGERALD Bethesda, Maryland 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) BURIAN/CREMATION. Burial (Specify) 8-21-67 Baptist Cemetery Salem. New Jersey 25b REGISTRAR S SIGNATURE 250 REC'D BY REGISTRAR 24 FUNERAL DIRECTOR ROBERT A PUMPHREY. Bethesda. VR A15 (4) 25M 1/67 Maryland 1987



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11325 11324 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAM: The low requires that the death certificate be executed within 24 hours after death. ly filled in by the funeral on papers. Pages I and within 72 hours after deat PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY Montgomery West Virginia **b** COUNTY MARYLAND b CITY OR TOWN (If autside corporate firmits, write RURAL and give nearest town)
Bethesda c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C LENGTH OF STAY IN 16 Berkeley Springs 47 days d NAME OF HOSPITAL OR INSTITUTION (If not in hosp tol, give street oddress) 20014 d STREET ADDRESS IS RESIDENCE ON A FARM? Route 1. Box 264 The Clinical Center, Bethesda, Maryland NO IK NAME OF remove_edrbon lost 4 DATE Month DECEASED (Type or print) Mark Nahar Upshur August DEATH 9. AGE (In years last birthdoy) 63 yrs 6 COLOR OR RACE 7 MARRIED X 8 DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS NEVER MARRIED Hours Male Negro WIDOWED 19 June 1904 DIVORCED 10c USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Engineer 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT or removal, and in COUNTRY INDUSTRY Washington, D.C. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Francis Upshur Ella Saint Pierre & Nahar 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT The Medical Recordidress 16 SOCIAL SECURITY NO. (Yes, no, ar unknown) (If yes give wor or dates of service) 151-18-7442 The Clinical Center, Bethesda, Maryland 2001, 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY. INTERVAL BETWEEN 5 ONSEL AND DEATH Hepatic Failure IMMEDIATE CAUSE (o). DUE TO Conditions, if ony, which gove 1 Lymphosarcoma 3 1/2 years rise to immediate couse (a), DUE TO stoting the underlying couse PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19 WAS AUTOPSY PERFORMED? YES X NO 200 ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 11 of Item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home form (City or town) (Stote) (County) factory, street, office bldg, etc.) Not While ot work of work 2). I certify that (x) (this haspital) aftended the deceased from July 5, 1967, to August 21, 1967, that (X) (we) last saw the deceased alive an August 21, 1967, and that death accorded at 12:01 M, from causes and an the date stated above. 22o. SIGNATURE 4 22b. DATE SIGNED 21 August 1967 director, page 3 should be filed v DIRECTOR MD. PHYS 22d ADDRESS The Clinical Center, National 22c. PHYSICIAN'S NAME (Type) Vincent T. DeVita, MD. Institutes of Health, Bethesda, Md. 20014 230 BURIAL, CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) REMOVAL (Specify) J-24-67 H rmony Lando er, Md. 24. FUNERAL DIRECTOR **ADDRESS** VR A15 (4) Wasnin, ton, Fraziers



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STA **FALTEHVO** 2. USUAL RESIDENCE (Where deceased lived, finstitution, Residence before admission) 1. PLACE OF DEATH o. STATE b. COUNTY o COLINTY .s p Maryland Montgomery Montgomery MARY, AND Pag à c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b (ITY OR TOWN (If outside corporate im ts CLENGTH OF STAY IN 16 write RURAL and give negrest town) Silver Spring U4644 Silver Spring d NAME OF HOSPITA, OR INSTITUTION (If not in hospital, give street address) d STREET AGORESS e IS RES OENCE ON A FARM? 105 East Franklin Avenue NO Te 105 East Franklin Avenue be executed within 24 haurs after death 3 NAME OF 4 DATE Year lkin. DECEASED OF DEATH Marcia August 19 67 (Type or print) IF UNDER I YEAR IF UNDER 24 HRS 9 AGE (In years S SEX 6 COLOR OR RACE 132 B. DATE OF BIRTH 7. MARRIEO NEVER MARRIED lost b rthdoy)
50 vrs. Months Dovs Jan 30. 1917 Female Caucasian WIOOWED DIVORCED land 2 12 CT ZEN OF WHAT 10b KIND OF BUSINESS OR 11 BIRTHPLACE (Stote or fore an country) 10o USUA, OCC. PATION (Give kind of work done COUNTRY? during most of working life, even if retired) Maruland Retired Secretary 14. MOTHER'S MAIDEN NAME Nettie Brown Robert A. Barbee IS WAS DECEASED EVER IN US ARMED FORCES?
(Yes, no, or unknown) (I yes give wor or dotes of service) 17 INFORMANT with n 72 E. Franklin Ave. rd pending r Chief Medical I Nelson E. Van Dercook S INTERVAL BETWEEN ONSET AND DEATH 1B. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) event PART I. DEATH WAS CAUSED BY 113711 IMMEDIATE CAUSE (o) This certificate should writing the ward DUE TO should be farwarded to the In any Conditions, if any, which gove rise to immediate couse (a), DUE TO stoting the underlying couse gud PART II OTHER'S GNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART ICO. 19 WAS AUTOPSY be used remayal PERFORMED' YES the certificate, 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port L or Port L of Item 18) 200. EXTERNAL CAUSE WAS 3 should PRIMARY I or CONTRIBUTING I CAUSE OF OEATH MEDICAL 20e PLACE OF NJURY (Home form (City or town) (County) (Stote) 20d INJURY OCCURRED 20c TIME OF INJURY Month, Doy, Year factory, street, office bldg., etc.) Not While ot work ot work 21. I certify that I taak charge of the remains described above held an Autapsy Inspection and in my apinian Natural causes Undetermined manner death resulted from Hamicide funeral directar CHIFF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE may be re **EXAMINER'S** 5 may 1 O FUNE Health 23h DATE THEREOF 23c NAME OF 23d LOCATION (City or Joyen) (County) 230 BURIAL CREMATION Rockville. Maryland Parklawn Cemetery 250 REC D BY REGISTRAR hones 434 Georgia Avenue VR A15ME (5) 1 DATE AUG Pumphrey. Inc. Silver Spring.



1 1 2		MARYLAND STATE DEPARTMENT OF HEALTH
The Sant		Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11326 CERTIFICATE OF DEATH
mental and 2 death 2 d		PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institut on Residence before admission)
a 2 = 2 = 1		o COUNTY Ontgomery b. City Or TOWN (If outside corporate limits, C. LENGTH OF STAY IN 1b) c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
hours after to the by the to the state of th		write RURAL and give nearest town) Silver Spring Sugar Spring
in 24 hour lilled-in-by papers. P	101	17 Forest Glen Road 1017 Forest Glen Rd. YES NO N
pletely fi		NAME OF First Middle Lost 4 DATE Month Doy Year DECEASED (Type or print) Harles Rayles Rayles 1855
ind campletely remove carbain on any event, with the carbain with the carb	5	SEX 6. COLOR OR RACE: 7 MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (in yours lost burthday) Months Doys Hours Min Male white WIDOWED DIVORCED Oct. 25, 1903 63 yrs.
be exected in and control of the angle of th	100	D. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?
ificate the hysician please on and and	13.	Electrical Engineer Engineering Rochester, New York U.S. A. FATHER S NAME 14. MOTHER'S MAIDEN NAME
th certification of the certif	15	Harry J. Van Jassel Was DECEASED EYER IN U. S ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Aggress 7 Forcest Glen Rd
e deat	- III I I I	WAS DECEASED EVER IN U.S. ARMED FORCES? 65, no, of Jinknown) (If yes give wor or dotes of service) 16. SOCIAL SECURITY NO. 17. INFORMANT 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c))
s that the did.		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (0) Chronic asthma + bronchitis ONSWAND DEATH
physicion signed librarial-in burial-in burial		Conditions, if ony, which gove (b)
w req ding p een si the bi		Istofing the underlying couse lost. (c)
AN: The law requires of or attending physic itate has been signed for use as the buriol-Health prior to burion.	NO.	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? PERFORMED? YES \(\sum \) NO
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours at Page 4 may be retained by the haspital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in-by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages should be filled with the State Dept. of Health prior to burial, cremation, ar remayal, and in any event, within the should be filled with the State Dept. of Health prior to burial, crematically and in any event, within the state of th	CERTIFICATION	200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW WIJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
O HOSPITAL OR ATTENDING PHYSICI Page 4 may be retained by the haspir o FUNERAL DIRECTOR: After this certificator, page 3 should be detached should be filed with the State Dept. of	MEDICAL	20x TIME OF INJURY Month, Doy, Year Hour o.m. 19 20d. INJURY OCCURRED While of work of the other
ENDING Ped by NIG be und be the State		21. I certify that (I) (this hospital) attended the deceased fram 1962, 19 to August 16, 1967, that (I) (we) last saw the deceased alive on March 27 1967, and that death occurred at 10 AM, fram couses and on the date stated above.
RECTOIL 3 shouth I with I		220. SIGNATURE Land M.D. ATTENDING DAMED. STAFF 22b. DATE SIGNED DIRECTOR PHYS. DAMED. PHYS.
SPITAL 0 4 may be NERAL DI For, page		PHYSICIAN'S Bennet A. Porter Jr. 22d ADDRESS (clesrille Rd., Silverspring Md.
TO HOSPITAL Page 4 may O FUNERALI director, page	23	o. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) TIAL-Transit Aug. 22, 1967 Covina, California
VR A15 (4)	1 7	FUNESAL OPECIORATER Colon Conta ADBRESS 4 Ga. Ave. 250. RECID BY REGISTRAR'S SIGNATURE
20 M 1/66	L	Varner E. Pumphrey Juneral Home Silver Spring, 1000, 1000 f



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 🚼 🕹 🕹 🕿 MEDICAL EXAMINER'S CERTIFICATE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH n COUNTY D CLENGTH DE STAY N IN b CITY DR TDWN (If outside carpo r CITY DR-TOWI corporate limits, write RURAL and give Jurest town d STREET ADDRESS IS RESIDENCE be farwarded to the Chief Medical Exam ner's Office along with form 10 in Item 18. Give Pages he Star hours after death NAME OF DECEASED OF DEATH (Type or print) NEVER MARRIED Months Dovs Hours WIDOWED within 72 haurs after death DIVORCED Ob. KIND OF BUS NESS OR OCCUPATION (Give kind of work done 12 CITIZEN OF WHAT employed achienes 13 FATHER S NAME be executed within pencil Venable CEASED EVER N ... S ARMED FORCES? 16 SOCIAL SECURITY NO permit. (Yes, no, or unknown) (If yes give wor or dotes of service pending" 74-16-9208 18. CAUSE OF DEATH (Enter only one couse per ne for (o), (b), and (c) ONSET AND DEATH PART I DEATH WAS CAUSED BY event IMMEDIATE (ALSE (o) Aneurysm, abdominal aorta, ruptured This certificate should writing the word Ony Conditions, if ony, which gove 1 (b) arteriosclerosis, generalized, severe rise to immediate couse (a), and in DUE 10 stoting the underlying couse last 19 WAS AUTD PSY PERFORMED? remayal. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(G) CERTIFICATION NO 20th EXTERNAL CAUSE WAS 20b DESCRIBE HOW NURY OCCURRED (Enter noture of noury in Part Lor Port Lof Item 18) shauld PRIMARY D or CONTRIBUTING D D. CAUSE OF DEATH crematian. 20e PLACE OF NJURY (Home, form 20c TIME OF INJURY Month Doy, Year 20d INJURY OCCURRED (City or fown) (County) (Sote) Hour o.m foctory, street, office bldg., etc.) Not While at work Inspection X Inquiry 29. 21. I certify that I taak charge of the remains described above, held an Autopsy (3), and in my apinian death resulted fram Natural causes Accident Suicide 🗍 Undetermined manner Ham cide the funeral director be retained CHIEF MEDICAL EXAMINER ACTUAL 22 DATE SIGNED ASS STANT MED CAL EXAM NER prior may be re FUNERAL I SIGNATURE DEPUTY MED CAL EXAM NER **EXAMINER'S** Health Bethesda. Address (Street, city town, or county) NAME (Type) 23c NAME DE 'EMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BURIA CREMATION 23b. DATE THEREOF (County) 0 Bur Lal (Specify) Parsons Cemetery 9-2-67 Salisbury, Maryland 256 REG CTPAR'S SIGNATURE 250 REC D 8Y REG STRAR VR A15ME (5) 6M 1/67 PUMPHREY, Bethesda, Mary

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11328 11329 CERTIFICATE OF DEATH death equires that the death certificate be executed within 24 hours after death funeral 1 and 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH o. COUNTY Montgomery o STATE Virginia b COUNTY Prince William y filled in by the fun on papers. Pages 1 o ythin 72 hours after d MARYLAND b CITY OR TOWN (If outside carparate limits, Bethesda Rural CLENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) 7 Days Quantico Rural d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) e IS RESIDENCE ON A FARM? 246 Third Ave. Naval Hospital YES K NO completely fi 3. NAME OF Middle DATE Day Year 3 DECEASED (Type or print) JOHN **EDWARD** WADDICK ever AUG 26 19 67 DEATH SEX 6 COLOR OR RACE IF UNDER 1 YEAR B. DATE OF BIRTH AGE (In years IF UNDER 24 HRS 7. MARRIED NEVER MARRIED remove birthday) Manths Davs signed by the attending physician and co burial-transit permit. Then please remo burial, cremation, or removal, and in anly Male June 15, 1906 Cauc WIDOWED DIVORCED TOa USUAL OCCUPATION (Give kind of work dane during most of warking life, even if retired)

MILITARY 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or fareign country) 12 CITIZEN OF WHAT COUNTRY? INDUSTRY Marine Corps Chicago, Illinois ÙŠĀ 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME aftending phys John Francis Waddick Emma Pokrant 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address 246 3rd Ave 16 SOCIAL SECURITY NO (Yes, no, acunknown) (If yes give war or dates of service) 224-54-3049 Marjorie Waddick (Wife) Quantico, Va. 18. CAUSE OF DEATH (Enter only one couse per fine for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (a) Left Cerebral Infarction Page 4 may be retained by the hospital or attending physician. DUE TO Arteriolosclerotic Hypertensive Cardiovascular Conditions, if ony, which gove Disease rise to immediate cause (a), DUE TO stating the underlying couse **5 FUNERAL DIRECTOR:** After this certificate has been director, page 3 should be detached for use as the should be filed with the State Dept. of Health priar to OR ATTENDING PHYSICIAN: The law WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) YES 4 NO 20g ACCIDENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. T.ME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form (City or town) (State) (County) Haur om factory, street, affice bldg., etc.) at wark at work O FUNERAL DIRECTOR: After 21. I certify that (1) (this haspital) attended the deceased fram Aug 19, 19 67, to Aug 26, 19 67, that (1) (we) last saw the deceased alive on Aug 26, 19 67, and that death accurred at 2:30AM, from causes and on the date stoted above. saw the deceased alive on Aug 26 22a. SIGNATURE 22b. DATE SIGNED ATTENDING M.D 27 August 1967 22c PHYSICIAN'S 22d. ADDRESS NAME (Type) Naval Hospital, Bethesda, Maryland Peter T. KIRCHNER 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION 23b. DATE THEREOF 23d LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) 30 AUK. Arlington National Arlington, Virginia Burial 24 FUNERA DIRECTOR Cunningham Montesetle Woodbridge, Va. 250 REC'D BY REGISTRAR 25b REGISTRAR S SIGNATURE VR A15 (4) 25M 1/67 Charles



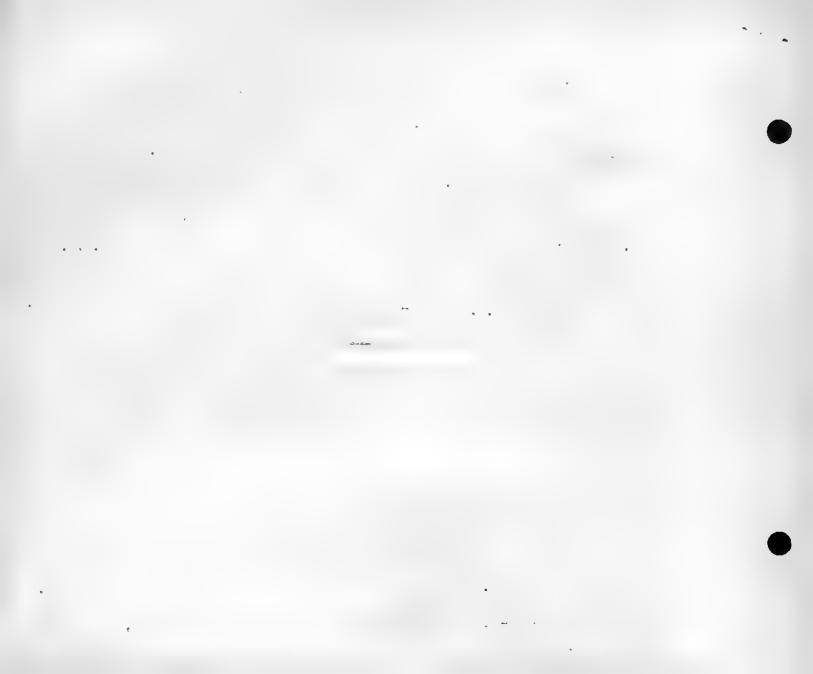
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۱	CEPTIFICATE OF DEATH	11530
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	a. STATE b. COUNTY	Y
	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MARYLAND MARYLAND O. CITY OR TOWN (if outside corporate limits, write write RURAL and give nearest town)	RURAL and give needs town
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1 .b	NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS	IS RESIDEN ON A FAR
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(Type	or print) Priva Wa Pricilla Walker DEATH AUGUST	17 1967
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	EMALE WHITE WIDOWED & DIVORCED ACGUST 8 1890 77 ym.	Months Days Hours Mir
10:	B. USUAL OCCUPATION (Give kind of work and defined) 10b. KIND OF BUSINESS OR INDUSTRY 1. BIRTHPLACE (County & Slete, or foreign country) 10b. KIND OF BUSINESS OR INDUSTRY 1. BIRTHPLACE (County & Slete, or foreign country)	12. CITIZEN OF WHAT COUNT
	FATHER'S NAME THE TOUSEWIFE MARYLAN	O_ USA-
	THORING B. MURAL	. 1
15	. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address	1
	Yas, no, or unkowh) (If yes give war or deles of service) 2/3-50-74/2	
	18. CAUSE OF DEATH [Enter only one cause per tine for (e), (b), end (c).) PART I. DEATH WAS CAUSED BY:	INTERVAL BETWEEN
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		(County) (State)
MEDICAL	Hour a.m. While Not While fectory, streat, office bldg., etc.)	
		1.7., 19.6.7, that (I) (we)
	saw the deceased alive on	
	22e. SIGNATURE ATTENDING MED. STAFF PHYS. DIRECTOR PHYS.	22b. DA SIG
	22c. PHYSICIAN'S 22d. ADDRESS	1 Comment
	NAME (Type) Frederick Moomau, M.D. medical Canta, Sans	dy Spring, M
23	BB. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town REMOVAL (Specify)	
-	FUNERAL DIRECTOR'S SIGNATURE FOR MANAGERS 3/6 E District 250. REC'D BY REGISTRAR 256. REG	Mary land
4	PONERAL DIRECTOR'S GONATORE PONERAL PROMETORES SPECE STORE AUG 2 1 1987	Charles Judges
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11336 CERTIFICATE OF DEATH carbon papers. Pages 1 and carbon within 72 nours after death 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) o. COUNTY o STATE b. COUNTY Montgomen MARYLAND lontaomer b. CITY OR TOWN (11 outside calparate limits c LENGTH OF STAY IN 16 CITY OR TOWN (If outside corporate limits, write RURA) and give nearest town write RURAL and give nearest town **CO HOSPITAL OR ATTENDING PHYSICIAN:** The low requires that the death certificate be executed within 24 hours. Page 4 may be retained by the hospital at attending physician Kensina .= d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? m: I 1405101ta YES NO 😿 NAME OF Middle Lost DATE Month Doy Year erely O DECEASED OF DEATH Walker ederick 26 (Type or print) 19 6 removol, and in ony event, compl 5. SEX 6. COLOR OR RACE IF UNDER 1 YEAR | IF UNDER 24 HRS 7 MARRIED NEVER MARRIED DATE OF BIRTH AGE (In years iost burthdoy) Months Doys Hours M WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CIT.ZEN OF WHAT offending physicion of permit. Then pleose during most of working life, even if retired) INDUSTRY JUDERVIS OF 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME CCLESTON IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMAN (Yes, no, or unknown) (If yes give wor or dates of service 5 AMASCI cremation, CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)
PART I DEATH WAS CAUSED BY INTERVAL BETWEEN ONSET AND DEATH burrol-transit IMMEDIATE CAUSE (o) á DUE TO signed l prior to buriol, Conditions, if any, which gove (b) rise to immediate couse (a). DUE TO stoting the underlying cause os the this certificate has been 19 WAS ALTOPS)
PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Health | NO. ior. 20d ACCIDENT WAS UNDERLYING [7] 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port 11 of item 18) OR CONTRIBUTING CAUSE OF DEATH detoched (IF E.THER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, (City or town) (Stote) (County) Hour o.m. factory, street, affice bldg , etc.) Not White at work at work 21 I certify that (1) (this haspital) attended the deceased from 3/1/66 and that death accurred at 4 6 TO FUNERAL DIRECTOR: saw the deceased alive an SIZY M, from lauses and on the date stated above 22g SIGNATURE 22b. DATE SIGNED STAFF DIRECTOR PHYS ed director, page should be filed ADDRESS 22d 22c. PHYSIC, AN'S NAME (Type) 23 BURIAL CREMATION 2367 DATE THEREOF 23m NAME OF CEMETERY OR CREMATORY (Stote REMOVAL (Specify) VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. I PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o COUNTY o STATE I ont comer; MARYLAND b CITY OR TOWN (flouts de corporate imits, c LENGTH OF STAY IN 1b c CITY OR TOWN (f auts de corporate l'mits, write RURAL and give nearest town) THE RURAN and give nearest town) Bethesda d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS S RESIDENCE ON A FARM? 8400 Wisconsin Ave.. in pencil in Item 18 Give Pages Suburban YES NO TE 3 NAME OF M ddle 4 DATE DECEASED 0. Jack Urcle Wamsley August 19 67 DEATH 6. COLOR OR RACE 7 MARR ED X NEVER MARR ED B. DATE OF BIRTH 9 AGE (In years IF UNDER I YEAR IF UNDER 24 HRS ost birthday) Doys Hours Male 11/30/1899 ony event within 72 hours ofter death White WIDOWED D VORCED 10a USUAL OCCUPATION (Give kind of work done during most of work ng life, even if rehired)
Gen. Manager 10b. K.ND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT INDUSTRY U.S.A. Govenor House Moto West Virginia please execute the certificate, writing the word "pending" in penal in I director. Pose 4 should be farwarded to the Chief Medical Examiners. 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Charles Wamsley Vinnie Fisher IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor ar dates of service) 578-09-2234 Same as Item 2. Freda Wamsley, wife 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY IMMEDIATE (AUSE (0) Fatty metamorphosis - 64 LIVEF . ONSET AND DEATH DUE TO Chronic alcoholism 4ears Conditions, if any, which gove use to immediate couse (a), DUE TO stoting the underlying couse PART I OTHER SIGNAL CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART (D) 19 WAS AUTOPSY PERFORMED? YES X NO 20o EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.1 3 should PRIMARY Or CONTRIBUTING CAUSE OF DEATH 20c TME OF NJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form ((ity or town) ((ounty) (Stote) Not While foctory, street, office bldg , etc.) at work 21 I certify that I took charge of the remains described above, held on Autopsy [X], Inquiry (X) Inspection (X) and in my opinion deoth resulted from: Notural causes X, Accident ... Suicide , Homicide Undetermined monner TO FUNERAL DIRE Health prior to b CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MED CAL EXAM NER SIGNATURE the funeral DEPUTY MEDICAL EXAMINER **EXAMINER'S** JOHN G. BALL Aduress (Street, city, town, or county) Bethesda. Md. NAME Type? 23b DATE THEREOF 23r NAME OF CEMETERY OR CREMATORY 230 BURIAL CREMATION. 23d LOCATION (City or Town) Burial (Specify) Parklawn Cemetery | Koc 8-12-67 Rockville Maryland
GISTRAR 25b REGISTRAR S SIGNATURE 24 FUNERAL D RECTOR VR A 15ME (5) PUMPHREY, Bethesda, Maryland 6M 167



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 OF The law requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. COUNTY monlyomek MARYLAND b CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Wheaton Washington, D.C. 1 m0 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) IS RESIDENCE d STREET ADDRE ON A FARM? YES NO 3. NAME OF Middle **DECEASED** wes (Type or print) Samue physician and camplet en please remave car DEATH buriar, cremation, ar remaval, and in any event S. SEX 8. DATE OF BIRTH IF UNDER 1 YEAR 6 COLOR OR RACE 7. MARRIED 9. AGE (In years **NEVER MARRIED** lost birthday) Months Dovs Hours WIDOWED DIVORCED 10o USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT during most of work ng life, even if retired) INDUSTRY Marylano COOURRNMEN] 14. MOTHER S MAIDEN NAME 13. FATHER'S NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMAN (Yes, no, or unknown) (If yes give wor or dotes of service Mrs Walter A. Brown - 121. Primrose 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).
PART I. DEATH WAS CAUSED BY: burial-transit ONSET AND DEATH IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician. DUE TO 17Ad ATLEROSCIEROSIS Conditions, if any, which gove rise to immediate couse (o), DUE TO stoting the underlying couse be detached far use as the State Dept. of Health priar to WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO X certificate 200 ACC DENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of Item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form (State) 20c TIME OF INJURY Month, Doy, Year (Erty or town) (County) Hour 'a.m. foctory, street, office bldg., etc.) 19 W to QUY 21. I certify that (1) (this haspital) attended the deceased fram 1967 that (1) (we) last 19 62, and that death accurred at 10 370 M, fram causes and an the date stated above. DIRECTOR: saw the deceased alive an aug 220 SIGNATURE 22b DAJE SIGNED MED. DIRECTOR director, page 3 shauld be filed v ADDRESS 22c. PHYSICIAN'S O FUNERAL NAME (Type) 4115 23o. BURIAL, CREMATION, 23b. DATE THEREO! 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) Rock Creek Cemetery Weghington Park Day REGISTRAN 8-17-1967 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67



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TO HOSPITAL OR ATTENDING PHYSICIAN: I Page 4 may be retained by the haspital or TO FUNERAL DIRECTOR: After this certificate director, page 3 shauld be detached for us shauld be filed with the State Dept. of Health		REMOVAL (Specify)	8-17	-67	A	armo	MI	ark	Z	and	nus	0)	701
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1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
FOR STATE	11234 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11306
HEALTH DEPT.	1. PLACE OF DEATH o. COUNTY MONT 90 MORY MARY AND 2. USUAL RESIDENCE (Where deceosed lived, if institution Residence before odmiss on) b. COUNTY b. COUNTY Mary And Mary And Mary And
th It any de ay is ges 1, 2, and 3, or farm *PW**** age at Deportment of hours after death	b CITY OR TOWN (if outside corporate limits, write RURA, and give nearest town)
It any s 1, 2, and a gram a P gram a gram	d NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) d STREET ADDRESS e IS RESIDENCE ON A FARM?
after death It. 8. Give Pages 1, alang with farm with the State De within 72 haurs	3 NAME OF DECEASED Research Month Doy Year OF
s after 18. Giv alang with t	S SEX 6 COLOR OR RACE 7 MARRIED 1 NEVER MARRIED 1 8 DATE OF RIPTH 19 AGE (In vents 1 IF LINDER 1 YEAR 1 5 ADER 24 HOS
n 24 hours on in item 18 ner's Office a ges land 2 w	M. WIDOWED DIVORCED JUNE 23, 1916 lost birthday) Months Days Hours Min 100 USUAL OCCUPATION (Give kind of work done during most of working life even fret-red) 100 K ND OF BUSINESS OR INDUSTRY 110 BIRTHPLACE (Stote or foreign country) 111 BIRTHPLACE (Stote or foreign country) 112 CITIZEN OF WHAT COUNTRY COUNTRY COUNTRY S. A.
d with n 24 hours after death II in pencil in Item 18. Give Pages Examiner's Office along with far File pages I and 2 with the State and in afterwith within 72 hour	13 FATHER'S NAME A. L Whiteman. 14 MOTHER'S MAIDEN NAME IN DIGITAL COTTINE!
xecuted wri nding" in pe Medical Exar permit. File	15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service) 578-24-0689 Gerald Frick, Potomac, Md.
irote shauld be on the word "pe ded to the Chief as o burial-transit or cremation, as re-	IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o). Conditions, if only, which gove rise to immediate couse (o), storing the underlying couse (o). (c)
This certificate, writificate, writificate, writificate, writificate for the following to the following for the followin	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS A JOPSY PERFORMED? YES NO 1
AINER: This he certificate shauld be files. 3 shauld be ent, prior ta	200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part I or Port II of Item 18) CALISE OF DEATH
Z = 4 = 9 g	20c TIME OF INJURY Month, Doy, Yeor Hour a.m. 19 20d IN.JRY OCCURRED 20e PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.) (City or town) (County) (State)
Mean Alphase execution of the control of the contro	21. I certify that I taak charge of the remains described above, held an Autapsy, Inspection X, Inquiry X, and in my apinion death resulted fram: Natural causes X, Accident, Suicide, Hamicide, Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL SIGNATURE ASSISTANT MEDICAL EXAMINER 22. DATE SIGNED
TO DEPUTY necessary, the funeral 5 may be 10 FUNERAL Health or i	EXAMINER'S NAME (Type) John G. Ball, M.D. DEPUTY MEDICAL EXAMINER & 8/1/67 Address (Street, city, town, or county)
TO D TO FI	230 BJRIAL (REMATION, REMOVAL (Specify) Burial Aug. 4,1967 Mt. Olivet Frederick, Md.
VR A15ME (5)	24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md. ADDRESS 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE AUG 7 1967 Cleveles Judge.



1 13	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
The state of the s		11335 CERTIFICATE OF DEATH	11337							
urs after death	1	PLACE OF DEATH o. COUNTY b. CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate limits, write RU	tion Residence before admission)							
hin 24 hours of filled in by the papers. Page thin 72 hours	1/2	write RURAL and give nearest town) Silver Spring d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) Holy Cross Hosp, tal 12213 Silver Spr.	et e, is residence ON A FARM? YES NO							
Page 4 may be retained by the haspital ar attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please femave carbon papers. Pages 1 and should be filled with the State Dept. of Health prar to burial, cremation, or removal, and in adveyor, within 72 hours after death the Cleared with the State Dept. of Health prar to burial, cremation, or removal, and in adveyor, within 72 hours after death the Cleared with the State Dept.	10	DECEASED	IF UNDER 1 YEAR IF UNDER 24 HRS Months Doys Hours Min 12 CITIZEN OF WHAT COUNTRY?							
the death certificate by attending physician permit. Then please from or removal, and the contract of the cont	13 15	13. FATHER'S NAME 14. MÖTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service) 16. SOCIAL SECURITY NO 17. INFORMANT 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)	INTERVAL BETWEEN							
D HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate by Page 4 may be retained by the haspital ar attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician director, page 3 should be detached far use as the burial-transit permit. Then please should be filed with the State Dept. of Health prar to burial, cremation, or removal, and clearly constructed to the please should be filed with the State Dept. of Health prar to burial, cremation, or removal, and		PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o) Acute myocardial in faretion Conditions, if ony, which gove is to immediate cause (o), stating the underlying cause (c) Lost. DUE TO (c)	ONSET AND DEATH							
ician: The I pital or atter rifficate has of far use as of Health pre	CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 200 ACCIDENT WAS UNDERLYING CONTRIBUTING CON	19 WAS AUTÖPSY PERFORMED? YES NO							
ENDING PHYS ed by the has et. After this ce ald be detache he State Dept.	MED,CAL	(IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19 20d. INJURY OCCURRED While of work	(County) (State)							
Page 4 may be retained by the haspital ar O FUNERAL DIRECTOR: After this certificate director, page 3 shauld be detached for us shauld be filed with the State Dept. of Health		Sow the deceased dive an system of the deceased dive and system of the deceased divergence di	22b. DATE SIGNED 16 7 Weaton, MO.							
TO HOSP Page 4 TO FUNE Should director	13	BURIAL (REMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City of To REMOVAL (Specify)) 3.0 BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City of To ADDRESS 250 RECD BY REGISTRAL 25b RECT BY RECT BY REGISTRAL 25b RECT BY RECT BY RECT BY RECT BY RECT BY RECT BY	OWN) _ (County) (State)							



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11336 CERTIFICATE OF DEATH 11308 PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. I. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institution. Residence before admission) o. COUNTY Montgomery o. STATE Maryland b. COUNTY Montgomery MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 1b Rodkville Rockville signed by the attending physician and completely filled in by burial-transit permit. Then please remove carbon papers. burial, cremation, ar remayal, and in any event, within 72 hou d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS TS RESIDENCE ON A FARM? Potomac Valley Nursing Home 4144 Great Oak Road YES NO DE NAME OF DECEASED (Type or print) Middle 4. DATE Lost Month WIEBE BEATRICE August 16. 19 67 DEATH 6 COLOR OR RACE 8 DATE OF BIRTH 9. AGE (In years IF UNDER I YEAR IF UNDER 24 HRS 7 MARRIED NEVER MARRIED lost birthdov) Months Doys Hours Female | White WIDOWED DIVORCED 28 . 1889 IT BIRTHPLACE (County & State, or foreign country) 100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b, KIND OF BUSINESS OR 12 CITIZEN OF WHAT INDUSTRY COUNTRY? Indiana 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Basil В. Spradley Ruth Pitman 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address ((es, no, or unknown) (If yes give wor or dates of service 317-26-7641D Thelma J. Obert-Item # 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I DEATH WAS CAUSED BY INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o' O HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if ony, which gave 1 (b) rise to immediate couse (o), DUE TO ed tar use as the L of Health prior to b stoting the underlying couse has been 2 mos PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 110 WAS AUTOPSY PERFORMED? 2 certificate NO V 200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH TO FUNERAL DIRECTOR: After this certification of director, page 3 should be detached should b≡ filed with the State Dept of (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED (City or town) 20c TIME OF INJURY Month, Dov. Year 20e PLACE OF INJURY (Home, form, (County) (Stote) Hour to m. foctory, street, office bldg., etc) Not While of work ot work 10. Wy 21. 1 certify that (1) (this hespital) attended the deceased from July 146 19 (c. /, that (l) (we) last . 19 11 1967, and that death accurred at 10:70PM, from causes and on the date stated above saw the deceased alive on all 22o. SIGNATURI 22b DATE SIGNED MED. DIRECTOR M.D. 13018 Georgia Ave., Silver Spring, 22c. PHYSICIAN'S NAME (Type) Ashby W. Smith 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION 23d LOCATION (City or Town) (County) (Stote) Bur-Transit 8/19/67 Parklawn Evansville, Indiana Tyson Wheeler Funeral Home-1331 Rockville Pike RECD BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 DATE AUG Rockville, Maryland



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11339 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission o. COUNTY o. STATE b. COUNTY c. LENGTH OF STAY IN 16 **b** CITY OR TOWN corporate limits, waste RURAL and give nearest town CCITY OR NOW .⊑ d MAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) IS RESIDENCE d. STREET YES NAME OF DATE Month Day DECEASED (Type or print) OF DEATH S SEX 6 COLÓR OR RACE 7. MARRIED AGE (In years IF UNDER IF UNDER 24 HRS h rthdoy) Months Dovs Hours WIDOWED DIVORCED 1Do USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of works INDUSTRY 13. FATHER'S NAME or removol. 17. INFORMANT (Yes, no, or unknown) (If was give wor or dates of service) 600 Mani 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c))
PART I. DEATH WAS CAUSED BY: burial-transit IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immediate couse (a), DUE TO tor use as the L Health priar to b stoting the underlying couse this certificate hos been last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) WAS AUTOPSY PERFORMED? NO X 200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER! 2Dc. TIME OF INJURY Month, Doy, Year 2Dd INJURY OCCURRED 2De PLACE OF INJURY (Home, form, (City or town) (Stote) (County) Hour 'o.m. While foctory, street, office bldg .etc.) Not While ot work After ot work 21. I certify that (I) (this hosyntal) attended the deceased fram. be retained TO FUNERAL DIRECTOR: saw the deceased aliveran. 8and that death occurred at 10 FIM. from causes and an the date/stated above 22o. SIGNATURE MED DIRECTOR director, page 3 should be filed a PHYS PHYS ADDRES 22c. PHYSICIAN'S NAME (Type) 23o. BURIAL, CREMATION, 23b DATE THEREOF NAME OF CEMETERY OR CREMATORY 23€ 23d LOCAT ON (City or Town) (County) (Stote REMOVAL (Specify) Maryland Parklawn Rockville. /19/67 Funeral Home-1991 Rockville Rockville, Maryland



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 3:540

CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a COUNTY a. STATE 6. COUNTY MARYLAND MONTGOMER b CITY OR TOWN (If ourside corporate limits, c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) TAKoma AKoma d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e IS RESIDENC ON A FARM? 8523 Glenview YES NOK 3. NAME OF Middle 4. DATE Dov Year DECEASED OF rertrude (Type or pnnt) NMN 196 DFATH 6. COLOR OR RACE NEVER MARRIED 9 AGE (In years IF UNDER IF JNDER 24 HRS last birthdov) Months Days Hours temale (aucasi on DIVORCED WIDOWED 10a USUAL OCCUPATION (Give kind of work done 10h KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or fareign country) during most of working life, even if retired) OWIL TOME none- Housewi none. 13. FATHER'S NAME Charles Wurdeman izabeth 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address (Yes, no, or unknown) (If we give wor or dates of service) Vurdeman, 8105 Flower Ave 18. CAUSE OF DEATH (Enter only one couse per line for-(a), (b), and (c).) INJERVAL BETWEEN PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause (a). DUE TO stoting the underlying couse 19 WAS AUTOPSY PERFORMED? PART II OFFER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) 20g ACCIDENT WAS JNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF IN. JRY (Harne, form, (City or town) (Caunty) (State) 9 Haur a.m. Not While factory, street, affice bldg., etc.) at work of work 21. I certify that (I) (this haspital) attended the deceased from 1967 1967, that (1) (we) last _, and that death accurred at 6 45 P.M. fram causes and an the date stated above. saw the deceased alive-on. 22o. SIGNATURE 22b. DATE SIGNED ATTENDING MED. DIRECTOR M.D PHYS PHYS 22d. ADDRESS 22c PHYSICIAN'S NAME (Type) 230 BURIAL CREMATION 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Equity) (State) REMOVAL (Specify) enwood 24 FUNERAL DIRECTOR Georgia Aueso REC D BY REGISTRAR HOME.

O HOSPITAL OR ATTENDING PHYSICIAN: "Page 4 may be retained by the haspital ar TO FUNERAL DIRECTOR: After this director, page 3 shauld shauld be filed with the VR A15 (4) 25M 1/67

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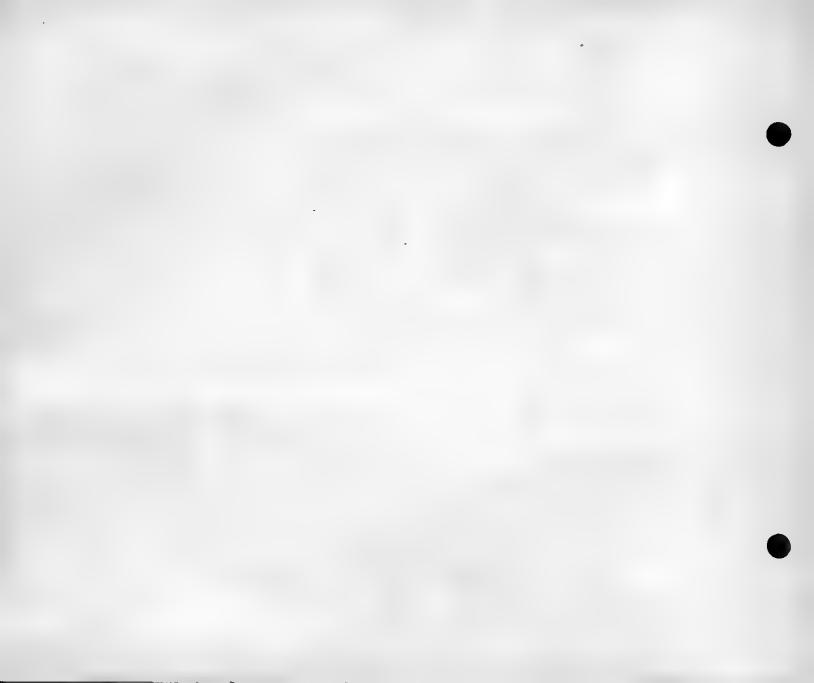
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The law requires that the death certificate be executed within 24 haurs after



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11339 completely filled in by the funeral tave carbon papers. Pages 1 and 2 ye even, within 72 haurs after death.). PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admissign) a. COUNTY o. STATE b. COUNTY c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) MARYLAND ont gomeru The law requires that the death certificate be executed within 24 haurs after b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address); IS RESIDENCE ON A FARM? Sanitarium and Hospital NO IX NAME OF 4. DATE Year DECEASED 19 67 (Type or pnnt) *4ugust* DEATH IF UNDER 24 HRS 6. COLOR OR RACE NEVER MARRIED AGE (In years IF UNDER 1 YEAR remavé lost birthdoy) Months DIVORCED | burial, crematian, ar remaval, and in any WIDOWED V and 10o USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) COUNTRY? INDUSTRY Comania 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending phys nermit. Then p 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, ar unknown) (If yes give wor or dotes of service) Hospital 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) INTERVAL BETWEEN signed by the burial-transit PART I DEATH WAS CAUSED BY. ONSET AND DEATH IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, fony, which gave redioNa scurar nse to immediate couse (a), **DUE TO** stating the underlying couse 10 FUNERAL DIRECTOR: After this certificate has been director, page 3 shauld be detached for use as the shauld be filed with the State Dept. of Health prior ta WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c) 20a ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form (City or town) (County) (State) Hour o.m. Nat While foctory, street, affice bldg., etc.) of wark 21. I certify that (1) (this hospital) attended the deceased from VONE 1965, to/700 196 / that (1) (we) last 79 67 and that death accurred at SUPM, fram causes and on the date stated above. saw the deceased alive an HOG 22b DATE SIGNED 220. SIGNATURE PHYS DIRECTOR 22d ADDRESS SHOKEFIELD K 22c PHYSIC AM O HOSPITAL LENKIA 23c., NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b DATE THEREOF (County) 24 FUNERAL DIRECTOR 250. REC D BY REGISTRAR

VR A15 (4) 25M 1/67



1	4	Items 18821 Film 392 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
FOR STATE		11340 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	1342
ofter death. If ony delay is she Foges 1, 2, ond 3 to Hearth farm. PM3. Page High the State Department of March the	3	PLACE OF DEATH MARYLAND b. COLLY MARYLAND b. COLLY MARYLAND b. COLLY MARYLAND c. CITY OR TOWN, (1) gottside carparate limits, write RURAL and give in the problem of the problem o	e IS RESIDENCE ON A FARM2 YES NO NO DOY YEAR JECHNOER 24 HRS DOYS HOJIS MIN
should be executed within 24 he word "pending" in pencil in to the Chief Medical Exominer's buriol-transit permit. File pages n ony event within 72 hours offer	13.	FATHER'S NAME HAMOTHER'S MANE WAS DECEASED EVER IN U.S. ARMED FORCES? WAS DECEASED EVER IN U.S. ARMED FORCES? It is social security no. If yes give wor or dates of service of the se	INTERVAL BETWEEN ONSET AND DEATH
A EXAM Recute the Page 4 for your DR: Page 3, cremarely	MEDICAL CERTIFICATION	Stating the underlying cause (c) PART II OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 200 EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING CAUSE OF DEATH 200 TIME OF INJURY Manth, Day, Year Hour a.m. pm. 19 20 MJLRY OCCURRED While at wark at war	19 WAS AUTOPSY PROFORMED? YES NO NO OTHER ORDER NO OTHER ORDER OTHER ORDER OTHER ORDER OTHER OTHER ORDER OTHER O
TO DEPUTY MEDICA necessory, please ex the funeral director. S may be retained TO FUNERAL DIRECTOR Health prior to burn	230	ACTUAL SIGNATURE EXAMINER'S NAME (Type) DEPUTY MEDICAL EXAMINER DEPU	22. DATE SIGNED 5/1967 County) (State)



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W, PRESTON STREET, BALTIMORE, MARYLAND 21201 11341 CERTIFICATE OF DEATH death. requires that the death certificate be executed within 24 hours after death uneral 1 and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a COUNTY "District of Columbia OUNTY Montgomery MARYLAND b CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 PTY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) Westwood, Md. Washington 126 days Bethesda d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? YES NO THE Naval Hospital 5507 Albia Rd. 20016 NAME OF DECEASED Middle carbon First Lost 4. DATE Year 67 Charles Wright ÛF George (Type or print) DEATH S. SEX 6. COLOR OR RACE IF UNDER 24 HRS 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH AGE (In years IF UNDER 1 YEAR remove lost Ajuthday) Aug 1902 Months Haurs Male Cauc signed by the ottending physician and co burial-tronsit permit. Then pleose remov burial, cremation, or removal, ond in ony WIDOWED DIVORCED 100 USUA: OCCUPATION (Give kind of work dane 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? U.S.A. INDUSTRY HSN Iowa 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Hamilton George Cyrus Wright IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (If yes give war ar dates of service) 5507 Albia Rd. WDC Mrs Estelle Wright 262-60-8105 Retired 18. CAUSE OF DEATH (Enter on the local balline for (a) (b), and (c))
PART I. DEATH WAS CAUSED BY. INTERVAL BETWEEN ONSET AND DEATH Brain Tumor IMMEDIATE CAUSE (o) be retained by the hospital or attending physicion. DUE TO Conditions, if any, which gove (b) rise ta immediate cause (a), DUE TO stoting the underlying cause ifter this certificate has been be detached for use as the State Dept. of Health prior to last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPS? PERFORMED? NO K 20g, ACCIDENT WAS UNDERLYING [1] 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I at Part II of Item 18) OR CONTRIBUTING CAUSE OF DEATH TO FUNERAL DIRECTOR: After this certification, page 3 should be detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Dov. Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Hame, form, (City or town) (Caunty) (State) foctory, street, affice bldg., etc.) Hauria.m. Not While at work of work 19 67 to 7 August 19 67 that (1) (we) lost 21. I certify that (I) (this haspital) attended the deceased fram___ 3 April director, page 3 should should should be filed with the August 1967, and that death accurred at 7:59 M, from causes and on the date stated above sow the deceased olive on 22a. SIGNATURE 22b. DATE SIGNED STAFF PHYS 8 Agust 1967 M.D. 22d ADDRESS 22c. PHYSICIAN S Naval Hospital, Bethesda, Md. NAME (Type) Unofrio 23d LOCATION (City or Town) 23c NAME OF CEMETERY OR CREMATORY 23g. BURIAL CREMATION 23b DATE THEREOF (State) PEMOVAL (Specify) Arlington, Va. Arlington National 8-10-1967 ADDRESS 2Sb REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR Gawlers Funeral Home 5130 Wisconsin Ave WDC VR A15 (4) 25M 1/67



MAKYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11344 CERTIFICATE OF DEATH 11342 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution. Residence before admission) · Montgomery Maryland Montgomery MARYLAND b (ITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours Silver Spring, ver Sprina d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS e IS RESIDENCE paper ON A FARM? Holy Cross Hospital 3501 Leisure World Blvd. NO 33 YES NAME OF Middie 4 DATE Year DECEASED
(Type or print) James Burton Zachary 1967 DEATH 6. COLOR OR RACE 8. DATE OF BIRTH 7 MARRIED NEVER MARRIED 9. AGE (in years IF UNDER 1 YEAR IF UNDER 24 HRS lost bythdoy) Months Hours 9/6/02 White WIDOWED DIVORCED Male 100 US_AL OCCUPATION (Give kind of work done during most of work natire, even if retired) 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT physician (nen please Alexandria, Virginia 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME emaval, Southey P. Zachary Maude Zachary attending p IS. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dotes of service) 16 SOCIAL SECURITY NO. 17 INFORMANT Mable C. Zachary 3501 Leisure 5 77**-0** 7- 740 7 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit cremat PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (0) ONSET AND DEATH signed by 1 DUE TO buriol Conditions, if any, which gave 1 rise to immediate cause (a). DUE TO stoting the underlying couse Page 4 may be retained by the haspital ar attending certificate has been PART J. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19 WAS AUTOPS use PERFORMED? NO ā 200 ACCIDENT WAS JNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Dov. Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form ((ity or town) (County) (Stote) Hour 'o.m. While Not While foctory, street, office bldg., etc.) of work ot work pe iospital) offended the deceosed from 1949 to lelea 1967, that (1) (we) last TO FUNERAL DIRECTOR: 1967, and that death occurred at 42 M, from causes and on the date stated above. saw the deceased alive ตก 220. SIGNADUS 22b. DATE FIGNED. STAFF M.D director, page should be filed PHYS 22c PHYSICIAN S 22d **ADDRESS** NAME (Type) 652 23c NAME OF CEMPTERY OR CREMATORY 230. BJRIAL CREMATION. 23b. DATE THEREOF 23d LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Rock Creek Cemetery 2So. REC'D BY REGISTRAR VR A15 (4) 25M 1/67 Silver Spring



FOR STATE 11343
HEALTH DEPT. PLACE OF DEATH

any delay is

PM3. Page

and 3 to

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necessory, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form

TO DEPUTY MEDICAL EXAMINER:

This certificate should be executed within 24 hours after death. If

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deoth.

Health prior to buriol, cremation, or removal, and in any event within 72 hours offer 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a buriol-transit permit. File pages

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VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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a. COUNTY		ry	MARYL	11	o. STATE Mary.		d, if institution: Res b. COUNTY	sidence befare	odmission)
write R	TOWN (If autside corporate limi URAI and give pearest town) SILVER SPRING		DOA.	lb i	CITY OR TOWN III	utside corporote limit IMOPE	s, write RURAL ond	give neorest i	rown)
d. NAME O	HOSPITAL OR INSTITUTION (IF HOS)	not in haspital, g	give street address)		STREET APPRESS Ne.	lson Ave.		e. YE	IS RESIDENCE ON A FARM? S NO
3. NAME OF DECEASED (Type or p	rint) Hyman	First	Middle NMI	Zit	lost come r	4. DATE OF DEATH	Month August	28 28	Year 19 6 7
S. SEX m	6. COLOR OR RACE	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8.	DATE OF BIRTH	9. AGE (82)	In years IF UN pirthday) Mont yrs.		Hours Min.
during most of	(UPATION (Give kind of work don working life even if refired) etired —cabir	net mak	ND OF BUSINESS OR DUSTRY Cer		Russia		12	COUNTRY? JSA	√HAT
13. FATHER'S	oh Zitomer				4. MOTHER'S MAIDEN Jnknown	NAME			
15. WAS DECE (Yes, no, or un	ASED EVER IN U.S. ARMED FOR CES (known) (If yes give wor or dates		SOCIAL SECURITY NO.	17. INF	ormant Son eph Zitor	mer_1331	olesvil	lle, M	ld. Rd.
Condition rise to in	ns, if any, which gave	10	oronary	Tr	isoffice	eney Ad	ute.		VAL BETWEEN T AND DEATH
PART II.	OTHER SIGNIFICANT CONDITIONS	CONTRIBUTING T	O DEATH BUT NOT RELAT	TED TO THE	TERMINAL DISEASE COI	NDITION GIVEN IN PA	RT 1(a)		VAS AUTOPSY ERFORMED? NO
	ERNAL CAUSE WAS or Contributing beath.	20b. DE	SCRIBE HOW INJURY OCC	URRED. (En	ter nature of injury in	Part I or Part II of it	tem 18.)		
20c. TIM	E OF INJURY Manth, Doy, Year Haur a.m. p.m. 19	While	Not While		OF INJURY (Hame, farn street, affice bldg., etc.)		or town)	(County)	(Stote)
	RE John	ge af the rem ral causes K	A	Suicide	, Hamicide	EXAMINER DICAL EXAMINER	, Inquiry () mined manner 8/28/	22.	n my opinion
NAME (T	ype) JOHN	G. BAL			Address (Street	t, city, tawn, ar coun		-	
230. BURIAL, O BUR	1(ALI) 8-29				Sital Heb	23d. LOCATION	. Washi	(County)	(State)
24. FUNERAL Berna		v & So	ns Washi	ator	2So. RECT	6 3 0 196	2Sb. REGISTRAR	es signature	udal.
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W, PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11346 requires that the death certificate be executed within 24 hours after death. by the funeral Pages 1 and 2 tours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o. STATE b. COUNTY Maryland Montgomery Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) filled in by the control of the cont write RURAL and give negrest town)
Chevy Chase Chevy Dhase e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS Mass. Ave. 5221 Mass. Ave. YES NO K 3. NAME OF First Middle 4 DATE DECEASED Zomborv August 1967 Margaret (Type or print) DEATH SEX IF UNDER 1 YEAR 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 24 HRS birthdoy) July 1880 WIDOWED DIVORCED IDo. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) COUNTRY? INDUSTRY Hungary Housewife Hungary 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Radacsy Eliz Balint Gyorgy 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) 5789 Daughter - Mararet Beky - Same as INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the buriol-tronsit ONSET AND DEATH PART I. DEATH WAS CAUSED BY. ARREST, CONGESTIVE CARDIAC IMMEDIATE CAUSE (o) __ DUE TO HYPERTENSIVE & ARTERIOSCLEROTIC 10-15 years HEART Conditions, if ony, which gove rise to immediate cause (a), DUE TO ESSENTIAL HYPERTENSTON ARTERIOSCLEROSIS 20 years stoting the underlying couse the 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO IX OBESITY OLD RECURRENT CHRONIC DIARRHEA 8-10 years AGE. YES T O FUNERAL DIRECTOR: After this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [detoched for the Dept. of H OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER! 20c. TIME OF INJURY Month, Doy, Year 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, form, 2Df. (City or town) (County) (Stote) foctory, street, office bldg., etc.) Not While ot work 21. I certify that (I) (this haspital) attended the deceased from December, 1965, toAugust 15, 1967, that (I) (we) last saw the deceased afive an August 15 19 07, prodeshat death accurred 3:30 PM, fram causes and an the date stated above. 22b. DATE SIGNED ATTENDING August 16.1967 DIRECTOR PHYS. director, poge should be filed 22d. ADDRESS PHYSICIAN'S 4966 Mac Arthur Boulevard, N. W. NAME (Type) Washington D.C. 20007 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (Stote) Burla Specify) Greenwood Cemetery Trenton, New Jerset ADDRESSWash. D.C. 2Sh. REGISTRAR'S SIGNATURE REC'D BY REGISTRAR FUNERAL/DIRECTOR 2So. Municipales VR A15 (4) Wis.Ave.N.W 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

